NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, DECEMBER 5, 2019
2:00 P.M.

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

~~**TELECONFERENCE LOCATION:**~~
~~**333 O'FARRELL, SAN FRANCISCO, CA 94102**~~

REVISED AGENDA

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 Doug Chaffee, Alternate

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

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

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

The Board Meeting Agenda and supporting 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. State Quality Award
   b. Community Partner Award
   c. New Executive Director, Operations
   d. America's Health Insurance Plans Meeting
   e. Medicaid Fiscal Accountability Rule
   f. California Advancing and Innovating Medi-Cal (CalAIM)
   g. Employee Engagement Survey
   h. State Medical Audit
   i. Health Education's Anti-Vaping Event

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 November 7, 2019 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the August 22, 2019 Special Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee and the September 12, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

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

4. Consider Approval of CalOptima's Health Homes Program Policies

REPORTS

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

6. Consider Authorizing and Directing Execution of Amendment(s) to the Primary Agreement with the California Department of Health Care Services

7. Consider Authorizing Further Actions Related to the California Department of Health Care Services Medi-Cal Provider Enrollment Requirements

8. Consider Approval of OneCare and OneCare Connect Polices related to Direct Member Reimbursement for Covered Services

9. Consider Approval of CalOptima Utilization Management Policy and Procedure Related to Palliative Care Services

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

11. Consider Approval of Modifications to CalOptima Long Term Services and Supports Policies and Procedures related to Annual Policy Review

12. Consider Adoption of Resolution Approving Revised CalOptima 2020 Compliance Plan and Authorizing the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures *Rev. 12/5/19*

13. Consider Approval of Homeless Health Initiatives Guiding Principles

14. Consider Authorizing Reallocation of Intergovernmental Transfer (IGT) Funds Previously Allocated for Recuperative Care to Housing Supportive Services; Consider Authorizing Contract(s) and/or Contract Amendment(s) with the County of Orange for Implementation

15. Consider Approval of CalOptima's 2020-2022 Strategic Plan

16. Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation

17. Consider Ratification of Amendments to the AltaMed Health Services Corporation Medi-Cal Health Network Contract, and Expenditures for Whole-Child Model Program Implementation

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

ADVISORY COMMITTEE UPDATES

19. Provider Advisory Committee Update

20. OneCare Connect Member Advisory Update

INFORMATION ITEMS

21. Delivery System Evaluation

22. October 2019 Financials

23. Compliance Report

24. Federal and State Legislative Advocates Reports ~~(Akin will be presenting)~~

25. CalOptima Community Outreach and Program Summary

CLOSED SESSION

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

CS 2 Pursuant to Government Code section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Paul Yost, M.D. and Dr. Nikan Khatibi)
Unrepresented Employee: (Chief Executive Officer)

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

MEMORANDUM

DATE:	November 26, 2019
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report — December 5, 2019, Board of Directors Meeting
COPY:	Sharon Dwiers, Interim Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

CalOptima Earns State Quality Award for the Fifth Year in a Row
Great news! CalOptima extended our run of recognition by the state, receiving the Department of Health Care Services (DHCS) Outstanding Performance Award for Large Scale Plans for the fifth year in a row. Presented recently at the regulator's annual quality meeting, CalOptima had staff on hand to accept the honor, with a certificate that states "in recognition of your efforts for going above and beyond for Medi-Cal managed care members…" Thanks to your Board and all providers for continuing to support this agency's efforts to lead California in Medi-Cal quality.

Community Health Centers Group Honor CalOptima for Partnership
On November 14, the Coalition of Orange County Community Health Centers honored CalOptima during the group's 45th anniversary event, presenting the agency with the Community Partner Award. I thanked coalition members for their partnership, emphasizing our longstanding shared mission to care for vulnerable populations as well as our current initiatives to better serve individuals experiencing homelessness through clinical field teams and other programs.

CalOptima Names New Executive Director, Operations
Former Customer Service Director Belinda Abeyta has been promoted to Executive Director, Operations. Belinda filled this role in an interim capacity for seven months, ensuring that CalOptima's day-to-day functions of serving members and ensuring provider payments ran smoothly. As Executive Director, Belinda is responsible for overseeing Customer Service, Grievance and Appeals Resolution Services (GARS), Claims Administration, E-Business and Coding Initiatives. She started her career with CalOptima in 2014 as director of GARS before moving into her Customer Service role. She has 25 years of leadership experience in claims for both public and private health care organizations, including Inland Empire Health Plan and St. Joseph Heritage Heath. She holds a bachelor's degree in health science from California State University, Long Beach and an MBA from University of Phoenix.

America's Health Insurance Plans (AHIP) Meeting Brings Opportunity to Interact With Key Federal Policy Makers
On November 12–13, I attend an AHIP Board meeting during which the association reiterated its Medicaid managed care focus on three areas: rates, coverage and benefits, and managed care plan value. Regarding rates, AHIP is monitoring block grant waivers, medical loss ratio guidance, and CMS rate reviews and rule changes, including the Medicaid Fiscal Accountability

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Rule (described below). Regarding coverage and benefits, AHIP is focused on waivers, the public charge rule and dual eligible integration. Finally, about managed care plan value, AHIP is examining research on quality and the impact of carve-outs. Further, the Board meeting was also valuable for the opportunity to connect with policy makers. Three senators with leadership roles on health care and financial committees made presentations, and I was part of a small group of six CEOs from public and commercial health plans invited to attend a private meeting with Alex Azar, secretary of U.S. Health and Human Services, which oversees the Centers for Medicare & Medicaid Services (CMS). During the meeting, Azar stated that his vision for health care centers on affordability, quality and choice. Finally, I was appointed to a new AHIP Administrative Committee, exploring how the association can strengthen service to the three "vertical" markets defined as Medicare, Medicaid and Commercial. AHIP plans even more commitment to Medicaid by hiring staff and bringing on other resources, and as part of the committee, I will help guide these efforts.

Medicaid Fiscal Accountability Rule Focused on More Transparent Financial Practices
On November 12, CMS released its draft Medicaid Fiscal Accountability Rule, which was proposed in response to federal Medicaid spending growth and concerns about financial transparency. In a fact sheet accompanying the rule, CMS stated that the intent of the proposed regulations is to strengthen the fiscal integrity of the Medicaid program and ensure that state supplemental payments and financing arrangements are transparent and value-driven. Three major provisions would: 1) strengthen state-level reporting requirements; 2) clarify Medicaid financing definitions and processes for "base" and "supplemental" payments; and 3) reduce questionable financing mechanisms. Regarding the third category, the rule would update some requirements around Intergovernmental Transfers (IGTs) and their funding sources as well as health care-related taxes and donations. At this stage, CMS is soliciting stakeholder input on the rule and will be accepting comments for 60 days.

California Advancing and Innovating Medi-Cal (CalAIM) Initiative Garnering Considerable Attention Statewide as Workgroup Meetings Begin
In the short time since the October 28 introduction of CalAIM, activity has ramped up quickly. DHCS held the first three workgroup sessions: Population Health Management and Annual Health Plan Open Enrollment (November 5), Behavioral Health (November 8), and Enhanced Care Management and In Lieu of Services (November 20). Another 19 sessions are planned through February 2020. CalOptima has clear visibility of the activity in the groups through our associations, Local Health Plans of California (LHPC) and California Association of Health Plans (CAHP). The workgroup sessions are highly structured, involving detailed PowerPoint presentations and specific written questions about which DHCS is seeking feedback. LHPC and CAHP are hosting weekly calls and compiling answers to the questions. Separately, the state and the associations are engaging outside of the meetings on topics in CalAIM but not covered by a workgroup, such as regional rate setting and long-term care integration. Public plans, including CalOptima, consider population health management, enhanced care management and in lieu of services the priority areas, since they have the earliest proposed implementation, starting 2021. In fact, an all-day meeting between the state and plan leaders about enhanced care management and in lieu of services was just announced for February 10, 2020. I will continue to share CalAIM updates with your Board.

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Employee Engagement Survey Results Show Positive Ratings, Highlight Opportunities
CalOptima shared results of the Employee Engagement Survey with employees during the All Hands meeting on November 14. DecisionWise administered the survey, and DecisionWise Senior Consultant David Long presented an overview that showed CalOptima's scores, highlighting areas receiving positive feedback and those needing improvement. He said that CalOptima's overall rating was 72% favorable and 18% neutral, which are similar to the averages seen across DecisionWise's large client base. Executive Director, Human Resources Brigette Gibb announced that workgroups have been formed to respond to three opportunities for improvement: cross-functional communication, professional growth and employee voice (being responsive to ideas and suggestions from employees). The workgroups, which include employees from various departments and at various career levels, started November 15.

State to Audit CalOptima in January, Delegated Entity to Participate
DHCS formally notified CalOptima about the annual medical audit of Medi-Cal and OneCare Connect (Medicaid-based services only). The regulator will be on site from January 27–February 7, 2020. DHCS will audit CalOptima's compliance with contractual and regulatory requirements in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity, for the review period of February 1, 2019, to January 31, 2020. A key difference in the 2020 audit is the requirement that a CalOptima delegate participate, and DHCS has chosen to engage Monarch HealthCare for its review of OneCare Connect.

Health Education Team Organizes Successful Anti-Vaping Event in Anaheim
CalOptima's Health Education team within the Population Health Management department partnered with community organizations to present Escape the Vape, an educational anti-smoking event targeted at school children. Held on November 21 at the Ponderosa Park Community Center in Anaheim, more than 300 children attended, many with a parent. The American Cancer Society was a key collaborator as the event coincided with the 40th anniversary of the Great American Smokeout, a nationwide effort encouraging smoking cessation. Escape the Vape included a dozen booths with information, entertainment and activities. The anti-vaping theme attracted TV coverage from Telemundo and KTLA.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

November 7, 2019

A Regular Meeting of the CalOptima Board of Directors was held on November 7, 2019, at CalOptima, 505 City Parkway West, Orange, California. Vice Chair Dr. Nikan Khatibi, called the meeting to order at 2.01 p.m. Director Penrose led the Pledge of Allegiance.

ROLL CALL

Members Present: Dr. Nikan Khatibi, Vice Chair; Ria Berger; Ron DiLuigi; Alexander Nguyen, M.D.; Lee Penrose; Richard Sanchez (non-voting); Scott Schoeffel; Supervisor Andrew Do (left meeting at 4:25 p.m.); Supervisor Michelle Steel (at 2:08 p.m.)

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

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

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

Michael Schrader, CEO, highlighted several items from his Report including officially welcoming to the CalOptima executive team Nancy Huang, Chief Financial Officer and Emily Fonda, M.D., Deputy Chief Medical Officer. Mr. Schrader also noted the October 16, 2019 Groundbreaking Ceremony for the Be Well OC Regional Mental Health and Wellness Campus in Orange.

Mr. Schrader also provided a detailed overview of the draft California Advancing and Innovating Medi-Cal Initiative (CalAIM) unveiled by the Department of Health Care Services (DHCS). He noted that CalAIM is a multiyear initiative designed to drive delivery system innovation and program and payment reforms in Medi-Cal in light of the expiration of the current Section 1115 and 1915(b) waivers in 2020. The state DHCS has formed five workgroups that will focus on the following areas: population health management and annual health plan open enrollment, National Committee for Quality Assurance (NCQA), enhanced care management, behavioral health, and full integration pilots. In addition, we will be working through our associations to be closely involved as the initiative evolves.

Mr. Schrader also provided brief updates on upcoming issues and initiatives including behavioral health integration, the executive order on pharmacy carve-out, the Healthy California for All Commission study on transitioning to a single payer, a legislative hearing focused on Medi-Cal managed care quality, CalOptima's Three-Year Strategic Plan and the CalOptima provider delivery system evaluation.

PUBLIC COMMENTS

1. Quynh Kieu, M.D. – Oral Re: pediatric services
2. Raman Chopra, M.D. – Oral Re: pediatric services
3. Dr. Kazi Rezai, D.O. – Oral Re: GG.1633 Board Certification Requirement
4. Martin Serota, Prospect Medical Systems – Oral Re: Agenda Item 6. Consider Authorizing Vendor Contract Amendment and Additional Funding for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the October 3, 2019 Regular Meeting of the CalOptima Board of Directors

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

REPORTS

3. Consider Approval of a Proposed CalOptima Policy and Procedure Related to the CalOptima Program of All-Inclusive Care for the Elderly Program

Vice Chair Khatibi noted that this item involves a staff recommendation to approve a policy related to payment of premiums and the collection of share-of-cost payments from PACE participants.

After considerable discussion, the Board took the following action:

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors Approve the following Policy and Procedure related to the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Program: A.) PA.7100: Premium & Share of Cost Collection [PACE] (Motion carried; 8-0-0)***

4. Consider Adopting Resolution Authorizing and Directing Execution of Amendment No. 1 to Contract MS-19-20-41 with the California Department of Aging for the Multipurpose Senior Services

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors adopted Board Resolution No. 19-1107-01, authorizing and directing the Chairman of the Board to execute Amendment No. 1 to Contract MS-19-20-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2019-20. (Motion carried; 8-0-0)***

5. Consider Authorizing Amendment to the Vision Service Plan HMO Services Contract for Enhanced Benefits

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors Authorized the Chief Executive Officer, with the assistance of Legal Counsel,***

to amend the Vision Service Plan (VSP) HMO Services Contract for OneCare (OC) and OneCare Connect (OCC) to reflect the additional frame and contact lens benefit allowance for members. (Motion carried;8-0-0)

6. Consider Authorizing Vendor Contract Amendment and Additional Funding for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System

Ladan Khamseh, Chief Operating Officer, introduced this item and noted that many of CalOptima's health networks have expressed a desire to meet with the consultants for the CalOptima Provider Delivery System to provide additional feedback.

Several Board members noted concern with the timing of the report and the increase dollar amount. After discussion on the matter, the Board took the following action:

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors 1) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's contract with Pacific Health Consulting Group (PHCG) to include additional work related to the evaluation of the CalOptima provider network delivery system; and 2) Authorized additional expenditures on this engagement of unbudgeted funds in an amount not to exceed $35,000 from reserves to fund the additional work covered by the proposed contract amendment.. (Motion carried; 8-0-0)***

7. Consider Approval of Homeless Health Initiatives Guiding Principles

The Board thanked staff for its work on this item and asked whether the guiding principles should be updated in light of the CalAIM proposal, which could go into effect as soon as 2021.

The Board also directed staff to include CalAIM as a standing item on future Board agendas and in the CEO Weekly Updates to the Board.

After considerable discussion, the Board took the following action:

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors directed staff to update the Guiding Principles document based on the proposed CalAIM initiatives and bring back to the December Board. (Motion carried; 8-0-0)***

8. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal***

Counsel, to amend the OneCare Connect Health Network contracts with AltaMed Health Services Corporation to: i.) Extend the OneCare Connect Health Network contract through and including December 31, 2020; ii.) Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program; and iii.) Clarify access standards for prenatal care. (Motion carried 5-0-1; Director Schoeffel absent; Supervisor Do abstained; Supervisor Steel recused)

9. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

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

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect: 1.) Health Network contracts with AMVI Care Health Network, ARTA Western California, Inc., Talbert Medical Group, P.C., Family Choice Medical Group Inc., Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network Inc., Monarch HealthCare, A Medical Group Inc., Orange County Physicians IPA Medical Group Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Prospect Health Plan Inc., and United Care Medical Group, Inc. to: i.) Extend the OneCare Connect Health Network contract through and including December 31, 2020; ii.) Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program; iii.) Clarify access standards for prenatal care; and 2.) Physician Hospital Consortium capitated Hospital contract with Fountain Valley Regional Hospital and Medical Center, and OneCare Connect Full-Risk Health Network contracts with Heritage Provider Network Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to incorporate the retrospective non-contracted Ground Emergency Medical Transport (GEMT) provider rate increase requirements for the July 1, 2018 through June 30, 2019 and the July 1, 2019 through June 30, 2020 periods, and the additional compensation to these Health Networks for such services. (Motion carried 6-0-1; Director Schoeffel absent; Supervisor Do abstained)***

10. Consider Authorizing Memorandum of Understanding with the Santa Ana Unified School District to Provide Outreach and Education Services
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Candice Gomez, Executive Director, Business Implementation introduced the item.

The Board directed staff to bring this item back to the Board for approval after the Memorandum of Understanding (MOU) is finalized and include as an attachment.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors, voted to continue this item until the Memorandum of Understanding is finalized and include as an attachment. (Motion carried; 7-0-0; Director Schoeffel absent)***

11. Consider Approval of the Expenditure of Funds to Host a Community Health and Resource Fair for CalOptima Members
This item was continued to a future meeting.

12. Consider Authorizing Contract with the Law Firms of Mansfield, Bronstein & Stone, LLP and Solowsky & Allen, P.L. (to follow Closed Session)
No action taken on this item.

ADVISORY COMMITTEE UPDATES

13. Member Advisory Committee Update
Christine Tolbert, MAC Chair, presented an update on the October 10, 2019 Joint Meeting of the CalOptima Board's four advisory committees. Ms. Tolbert shared that the MAC received presentations on Whole Person Care and Health Homes Program that highlighted the key aspects of each of the programs. She also shared MAC's feedback related to the draft CalOptima 2020-22 Strategic Plan.

14. OneCare Connect Member Advisory Committee Update
Patty Mouton, OCC MAC Chair, presented an update on the October 10, 2019 Joint Meeting of the CalOptima Board's four advisory committees. Ms. Mouton shared the OCC MAC's feedback related to the draft CalOptima 2020-22 Strategic Plan. She also noted they are looking at the current makeup of the representative seats on the OCC MAC to ensure they best reflect the needs of CalOptima's population.

15. Provider Advisory Committee Update
Teri Miranti, PAC Vice Chair, presented an update on the October 10, 2019 Joint Meeting of the CalOptima Board's four advisory committees. Ms. Miranti shared the PAC's feedback related to the draft CalOptima 2020-22 Strategic Plan. As the health network representative, Ms. Miranti thanked

the Board for allowing additional time for the health networks to meet with the provider delivery system consultants and also for the feedback on the Guiding Principles document.

INFORMATION ITEMS

16. Housing Options in Orange County

Julia Bidwell, Director of Housing & Community Development at the County of Orange, presented an overview of housing programs in Orange County including Affordable and Supportive Housing, Orange County Housing Authority, Mental Health Services Act Housing, and the Orange County Housing Finance Trust, including their current housing funding strategy. Ms. Bidwell introduced Lilly Simmering, Assistant Deputy Director, Orange County Health Care Agency.

Ms. Simmering provided an overview of the Medi-Cal population and the roles of the County and CalOptima. She noted that CalOptima is responsible for those with mild to moderate mental health issues, and the County is responsible for those who have Serious and Persistent Mental Illness and/or have a Substance Use Disorder.

17. CalOptima Draft 2020-2022 Strategic Plan Update

Athena Chapman and Caroline Davis from Chapman Consulting reviewed the draft 2020-22 CalOptima Strategic Plan, noting the key areas of focus for CalOptima that were agreed upon throughout the strategic planning process with input from the CalOptima Board, community stakeholders, and staff. These included: Innovate and Be Proactive, Increase Value and Improve Care Delivery; Expand CalOptima's Member Centric Focus; Enhance Operational Excellence and Efficiency; and Strengthen Community Partnerships. The final 2020-22 CalOptima Strategic Plan will be presented at the December Board for approval.

18. Hospital Data Sharing Update

Len Rosignoli, Chief Information Officer, provided an update on the hospital and community partner data sharing project. Mr. Rosignoli reported that CalOptima has partnered with the Orange County Health Care Agency (HCA) on the Whole Person Care (WPC) Program and the system used for communicating data for the WPC is known as WPC Connect. Mr. Rosignoli provided additional information on related projects and introduced Melissa Tober-Beers, Strategic Projects Manager, Orange County Health Care Agency, who provided an update on the Whole Person Care Data Sharing project.

Ms. Tober Beers provided background on the WPC Connect Care Coordination, highlighting benefits of using this system including: reducing inappropriate or unnecessary ER visits/inpatient utilization; meets needs in real-time: social, medical and behavioral; increased readiness for coordinated entry process, improved/increased success in housing placement. Ms. Tober-Beers noted that WPC via WPC Connect Services to all populations include: emergency room notification system, web-based collaborated care plan accessible by multiple organizations, automated referral to recuperative/medical respite care services, hospital and clinic-based care navigation/ coordination, managed care personal services coordinator (CalOptima), supportive and linkage services by shelter bed providers, housing sustainability services, including peer support, community resource referrals.

19. Health Homes Update

Candice Gomez, Executive Director, Program Implementation, provided an update on the general program requirements and CalOptima's rational for utilizing the existing health network infrastructure to be the community-based care management entities (CB-CMEs) and also noted that CalOptima is looking at ways to partner with the County of Orange.

Nancy Huang, Chief Financial Officer, provided an update on the financial aspects of the Health Homes Program, noting that by design the state selected the higher cost members to be enrolled in HHP and is providing higher rates for these members initially. Although, the funding will be reduced eventually, CalOptima anticipates that the cost will likely be neutral due to the intense case management requirements of the HHP population leading to improved health for these high-cost members.

The following Information Items were accepted as presented:
20. September 2019 Financials
21. Compliance Report
22. Federal and State Legislative Advocates Report
23. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURN TO CLOSED SESSION

CS1 CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
The Board of Directors adjourned to closed session at 5:45 p.m. Initiation of litigation pursuant to paragraph (4) subdivision (d) of Government Code section 54956.9: (One Case)

The Board reconvened to open session at 6:14 p.m. with no reportable action taken.

Hearing no further business, the meeting was adjourned at 6:14 p.m.

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

Approved: 12/5/2019

MINUTES

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

August 22, 2019

The Special Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) was held on August 22, 2019 at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Gio Corzo called the meeting to order at 3:02 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Gio Corzo, Chair; Patty Mouton, Vice Chair (at 3:12 p.m.); Adam Crits, M.D. (non-voting); Sandy Finestone; Keiko Gamez; Sara Lee; Donald Stukes.

Members Absent: Josefina Diaz; Mario Parada; Erin Ulibarri (non-voting), Jyothi Atluri (non-voting)

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Emily Fonda, M.D., Medical Director, Medical Management; Betsy Ha, Executive Director Quality and Population Health Management ; Shamiq Hussain, Sr. Policy Advisor Government Affairs; Irma Munoz, Project Manager, Quality Analytics; Dr. Edwin Poon, Director Behavioral Health Integration; Pallavi Patel, Director Process Excellence; Albert Cardenas, Director, Customer Service (Medicare); Samantha Fontenot, Program Assistant, Customer Service.

Chair Corzo reordered the agenda to hear CEO and Management Reports while waiting to achieve quorum.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, provided a verbal update on the Board of Directors' Strategic Planning Session that was held on August 9, 2019 with Chapman Consulting. This planning session was to assist with the development of a three-year Strategic Plan for fiscal years 2020-2022. Mr. Schrader noted that in addition to Chapman Consulting, California Secretary of Health and Human Services Dr. Mark Ghaly attended the planning session. Mr. Schrader also reported that the outcome from the Strategic Planning Session identified five key areas CalOptima would be focusing on going forward and noted that the October 10, 2019 Joint Meeting of the Advisory Committees would allow for input on the draft Strategic Plan.

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Chief Medical Officer Update
David Ramirez, M.D., Chief Medical Officer, provided a verbal update on the Homeless Health Initiative. Dr. Ramirez noted that at the August 1, 2019 Board of Directors' meeting the Board approved funding for Federally Qualified Health Clinics (FQHCs) to provide treatment to homeless members regardless of their health network assignment. Dr. Ramirez also reported that the Department of Health Care Services (DHCS) has released their telehealth guidelines which CalOptima is considering incorporating to improve access and member experience.

MINUTES

Approve the Minutes of the April 25, 2019 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Sandy Finestone, seconded and carried, the Committee approved the minutes of the April 25, 2019 meeting. (Motion carried 6-0-0; Members Diaz and Parada absent)***

PUBLIC COMMENT

There were no requests for public comment

REPORTS

Consider Approval of FY 2019-2020 OCC MAC Meeting Schedule
OCC MAC members reviewed the proposed FY 2019-20 meeting schedule. As proposed the OCC MAC would continue to meet on a bi-monthly basis the fourth Thursday of the month beginning at 3:00 P.M with the exception of the December meeting which will be held the third Thursday due to the upcoming holidays.

Action: ***On motion of Vice Chair Mouton, seconded and carried, the Committee approved the FY 2019-2020 OCC MAC Meeting Schedule. (Motion carried 6-0-0; Members Diaz and Parada absent)***

Consider Recommendation of Chair and Vice Chair
A letter of interest was received from Vice Chair Patty Mouton, Seniors Representative for the Chair position. After no further nominations from the floor, Chair Corzo requested a motion to recommend Vice Chair Mouton as OCC MAC Chair for FY 2019-2020.

Action: ***On motion of Member Sara Lee, seconded and carried, the OCC MAC approved the recommendation of Vice Chair Mouton for a one-year term as the OCC MAC Chair. (Motion carried 6-0-0; Members Diaz and Parada absent)***

A letter of interest from current OCC MAC Chair Gio Corzo, Community Based Adult Services Representative was received for the Vice Chair position. After no further nominations from the floor, Vice Chair Mouton requested a motion to recommend Chair Corzo as the OCC MAC Vice Chair for FY 2019-2020.

Action: ***On motion of Vice Chair Mouton, seconded and carried, the OCC MAC approved the recommendation of Chair Corzo for a one-year term as the OCC MAC Vice Chair. (Motion carried 6-0-0; Members Diaz and Parada absent)***

INFORMATION ITEMS

Federal & State Legislative Update

Shamiq Hussain, Sr. Policy Analyst, Government Affairs provided a verbal update on the Federal and State Budgets. Mr. Hussain reported that Proposition 56's (Tobacco Tax) newly proposed supplemental payments would remain in their current form and current payment levels until December 1, 2021. Mr. Hussain also provided an update on the expansion of Medi-Cal services to undocumented persons starting with those people between the age of 19 and 25, which is expected to go into effect no sooner than January 1, 2020. He noted that the California Legislature anticipates that there will be approximately 90,000 new Medi-Cal enrollees across the state due to the expansion. Mr. Hussain also provided an update on the status of the pharmacy carve-out, which was initiated through Governor Newsom's Executive Order in January 2019.

Health Homes Program Update

Pallavi Patel, Director, Process Improvement, provided a verbal update on the Health Homes Program (HHP). Ms. Patel noted that OneCare Connect members could self-refer into the HHP or their provider could refer them into the program. She also noted that the HHP is focused on integrating physical and behavioral health services for CalOptima members and will begin January 1, 2020 for members with chronic conditions and July 1, 2020 for members with serious mental illness or without a chronic condition.

Behavioral Health Update

Edwin Poon, Ph.D., Director, Behavioral Health Services presented on the OneCare and the OneCare Connect Behavioral Health Implementation. Dr. Poon noted that at their May 2, 2019 meeting, the Board approved the behavioral health implementation for OneCare and OneCare Connect which will become effective January 1, 2020.

Annual Healthcare Effectiveness Data and Information Set (HEDIS) Report

Irma Munoz, Lead Project Manager, Quality Analytics, presented the updated annual HEDIS 2019 report for Medi-Cal, OneCare, and OneCare Connect. Ms. Munoz noted CalOptima's Medi-Cal results for all the DHCS Minimum Performance Levels (MPLs) have been met. For OneCare the measures performed higher than in 2018, and for OneCare Connect, the measures were also higher than 2018 results. Ms. Munoz also noted that there are opportunities for additional improvement in each category.

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OCC MAC Member Updates

Chair Corzo also reminded the members that a joint meeting with the Member Advisory Committee, Provider Advisory Committee and the Whole-Child Model Family Advisory Committee would be held on October 10, 2019 at 8:00 a.m. to review the draft Strategic Plan as well as a presentation comparing the Health Homes and Whole-Person Care Programs.

ADJOURNMENT

Chair Corzo announced that the next regular meeting will be held on Thursday, October 24, 2019 at 3:00 p.m.

Hearing no further business, the meeting adjourned at 4:29 p.m.

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

Approved: October 24, 2019

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MINUTES

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

September 12, 2019

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, September 12, 2019, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

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

ESTABLISH QUORUM

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Donald Bruhns; Tina Bloomer, MHNP; Junie Lazo-Pearson, Ph.D.; Craig Myers; Jacob Sweden, M.D.; Dr. Anja Batra, (8:14 A.M); Dr. John Kelly; Dr. Loc Tran; Jena Jensen.

Members Absent: Pat Patton, MSN

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Nancy Huang, Interim Chief Financial Officer; Gary Crockett, Chief Counsel; Michelle Laughlin, Executive Director, Network Operations; Betsy Ha, Executive Director, Quality and Population Health Management; Tracy Hitzeman, Executive Director, Clinical Operations; Shamiq Hussain, Sr. Policy Advisor, Government Affairs/Legislative Affairs; Samantha Fontenot, Program Assistant.

On behalf of the PAC, Chair Nishimoto recognized former PAC members Steve Flood, Long Term Services and Supports Representative, and Mary Pham, Pharm D., Pharmacy Representative for their six years of service on the PAC.

MINUTES

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

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the August 8, 2019 meeting. (Motion carried 11-0-0; Member Patton absent)***

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PUBLIC COMMENTS

1. Michael Weiss M.D., Children's Hospital of Orange County - Oral re: Agenda Item VI. A. Network Strategy Project
2. Sam Roth, Tenet Healthcare – Oral re: Agenda Item VI. A. Network Strategy Project

CEO and MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, introduced Tim Reilly of Pacific Health Consulting Group (PHCG) who would be providing the Network Strategy Presentation.

INFORMATION ITEMS

Network Strategy Project Presentation

Tim Reilly, Founder and Partner of PHCG presented on CalOptima's Network Strategy Project. Mr. Reilly's presentation was similar to the one that was presented at the CalOptima Board meeting on September 5, 2019. After considerable discussion, the PAC asked that PHCG return to the November 14, 2019 PAC meeting with the recommendations in order for PAC members to have an opportunity to provide additional feedback prior to the Board taking action.

Federal and State Budget Update

Shamiq Hussain, Sr. Policy Advisor, Government and Legislative Affairs provided a verbal update on the Federal and State Budgets. He noted that the Department of Health Care Services (DHCS) was in the midst of implementing an expansion of full-scope Medi-Cal for the undocumented population for ages 19-25, which is the majority of the remaining uninsured in California He also noted that the 2019-2020 budget continues current payments and funds new payments via Proposition 56 (Tobacco Tax) dollars. These new payments are designed to incentivize the delivery of specific services, such as well-child visits, tobacco-use screening, and behavioral health treatment. Mr. Hussain also noted that DHCS continues to work on the transition of the Medi-Cal pharmacy benefit from managed care to state-administered fee-for-service, including a request for proposal process to procure a statewide pharmacy services administration as well as a stakeholder feedback process.

PAC Member Updates

Chair Nishimoto reminded the PAC members of their upcoming annual compliance training, and also noted that the next meeting will be a joint meeting which will include members from the Member Advisory Committee, OneCare Connect Member Advisory Committee and the Whole Child Model Family Advisory Committee to hear information on CalOptima's proposed Strategic Plan. The joint meeting is scheduled for October 10, 2019 at 8:00 a.m.

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ADJOURNMENT
There being no further business, Chair Nishimoto adjourned the meeting at 9:21 a.m.

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

Approved: November 14, 2019

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

At the December 6, 2018, meeting, the Board approved changes to CalOptima Policy GA.3400: Annual Investments. At that time, staff, in conjunction with Meketa Investment Group, Inc., and CalOptima's investment managers, Payden & Rygel, MetLife (formerly Logan Circle Partners) and Wells Capital Management, recommended revisions to the AIP to:

- Increase the maximum term of Operating Fund from four hundred fifty (450) days to two (2) years, unless otherwise specified in the policy;
- Revise language to allow Corporate Securities that are "rated 'A' or better" to rated "A" in the allowed portfolio;
- Add the Secured Overnight Financing Rate to the allowed index list of Variable and Floating Rate Securities; and
- Update the definition for State and California Local Agency Obligations in the glossary to be consistent with the California Code.

Discussion
Payden & Rygel, MetLife, and Wells Capital Management, CalOptima's investment managers, and Meketa Investment Group, Inc., CalOptima's investment adviser, submitted proposed revisions to CalOptima Policy GA.3400: Annual Investments for Calendar Year (CY) 2020. Staff compiled the proposed revisions and members of the IAC reviewed these proposed revisions and provided additional feedback.

Management recommends the following changes to CalOptima Policy GA.3400, upon Board approval:

- Section II.A.4.a.: Clarify policy that the primary benchmark for each investment portfolio is to be based on published market indices and custom peer group reports, as necessary, for short-term

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investments; and provide timeframes and responsible parties to review the performance benchmarks;

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

    - Section III.D.2.c.i.: State and California Local Agency Obligations, allow investments with an "A-" rating or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long term obligations;

    - Section III.D.2.e.i.a) and b): Commercial Paper (CP), modify the criteria for allowable investments, including that it is of "prime" quality of the highest ranking or of the highest letter and number rating as provided by a NRSRO, and that the issuing entity meets specified conditions;

    - Section III.D.2.g.i.: Repurchase Agreements, allow investments with rating of F1 short-term or A long-term or better by Fitch Ratings Service;

    - Section III.D.2.h.i.: Corporate Securities, allow investments with an "A" rating category or its equivalent or better by a NRSRO;

    - Section III.D.2.k.iii.a): Mortgage or Asset-backed Securities, modify language to allow investments with rating of "AA" or better or equivalent by a NRSRO or be rated at least "A-1" or the equivalent by a NRSRO for money market asset backed securities. This change is consistent with the CP section of the policy;

    - Section III.D.2.k.iii.b): Mortgage or Asset-backed Securities, remove to comply with the January 1, 2019 revision to the CGC that removed the requirement that the securities' issuer be rated "A" or its equivalent or better for the issuer's debts in accordance with a NRSRO;

    - Section III.D.2.m.ii.: Supranational Obligations, modify language to allow investments with a rating category of "AA" or its equivalent or better by a NRSRO;

- Section III.E.6.i.: Diversification Guidelines, clarify that if an Investment Manager exceeds the diversification limits, they are required to inform CalOptima's Treasurer and Investment advisory consultant, if any;

- Section III.H.7.: Investment Restrictions, clarify the entities (i.e., CalOptima's Treasurer, Investment Managers, Investment Advisory consultant, IAC) who will receive or be notified of a list of prohibited investments from the Board of Directors, if it exists;

- Revisions to Glossary Terms: Investment Advisor(s), Investment Advisory Committee (IAC) and Nationally Recognized Statistical Rating Organization (NRSRO).

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

Of note, Staff received a recommended change for a 5% portfolio maximum limitation per credit counterparty and by instrument type to include State and Local Agency Obligations (Municipal Bonds), Commercial Paper, Negotiable Certificates of Deposit, and Corporate Securities. However, since that potential revision would require additional vetting by CalOptima's investment managers and committee members, the recommendation will be discussed at upcoming IAC meetings for possible recommendations for adoption in a future policy update.

At its October 21, 2019, meeting, the IAC recommended that the Finance and Audit Committee (FAC) recommend Board approval of the proposed revisions to CalOptima Policy GA.3400: Annual Investments. The FAC recommended Board approval at its November 15, 2019, meeting.

Fiscal Impact
There is no immediate fiscal impact.

Rationale for Recommendation
The proposed changes to CalOptima Policy GA.3400: Annual Investments reflect the recommendations of CalOptima's investment managers, Payden & Rygel, MetLife, and Wells Capital Management, and concurrence by the IAC members and CalOptima's investment adviser, Meketa Investment Group, Inc. These recommended changes continue to support CalOptima's goals to maintain safety of principal and achieve a market rate of return while maintaining necessary liquidity during periods of uncertainty. Per the review conducted by Meketa Investment Group, Inc., there were no changes in the California Government Code affecting local agencies noted for the CY 2020.

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

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

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

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Policy ~~#:~~:	GA.3400
Title:	**Annual Investments**
Department:	CalOptima Administrative
Section:	Finance
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/~~18~~2018
~~Last Review Date:~~	~~01/01/19~~
~~Last~~ Revised Date:	~~01/01/19~~TBD

~~*Board Approved Policy*~~

FOR 2/19/20 BOD REVIEW

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

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A. Delegation of Authority

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

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

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

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

B. **CalOptima Treasurer** Responsibilities

1. The **Treasurer** shall be responsible for:

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

    b. The oversight of CalOptima's ~~investment portfolio~~**Investment Portfolio**;

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

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

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

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

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

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

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

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

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C. **Investment Advisory Committee**

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

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

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

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

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

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

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

D. Permitted Investments

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

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

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

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

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

2. Permitted investments shall include:

   a. U.S. Treasuries

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

ii. U.S. Government securities include:

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

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

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

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

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

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

iv. Maximum Term: ~~———~~

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

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

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

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

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

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

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

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

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

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

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

c. **State and California Local Agency Obligations**

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

ii. Maximum Term:

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

d. Banker's Acceptances

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

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

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

ii. Maximum Term:

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

e. **Commercial Paper (CP~~)~~)**

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

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~~a) Rated P-1 by Moody's,~~**CP** of "prime" quality of the highest ranking or ~~A-1, or better, by Standard & Poor's;~~

~~b)~~a)~~Have an A, or higher,~~of the highest letter and number rating ~~for the issuer's debt, other than CP, if any,~~ as provided for by ~~Moody's, or Standard & Poor's;~~ a nationally recognized statistical rating organization (NRSRO);

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

(1) The entity meets the following criteria:

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

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

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

(2) The entity meets the following criteria:

(A) Is organized within the ~~U.S.~~United States as a special purpose ~~corporations, trusts, or LLCs, which have~~corporation, trust, or limited liability company.

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

~~(A)~~(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by ~~a nationally recognized statistical rating agency; and~~ an NRSRO; and

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

ii. Maximum Term:

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

f. **Negotiable Certificates of Deposit**

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

ii. Maximum Term:

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

g. **Repurchase Agreements**

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

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

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

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

d) The Agent will notify CalOptima's custodian and CalOptima if the ~~valuation~~**Valuation** of the ~~collateral securities~~**Collateral Securities** falls outside of policy. Upon direction by the **CalOptima Treasurer**, the Agent will liquidate the ~~collateral securities~~**Collateral Securities** if any deficiency in the required one

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hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such ~~valuation~~**Valuation**.

ii. Maximum Term:

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

iii. Reverse ~~repurchase agreements~~**Repurchase Agreements** are not allowed.

h. **Corporate Securities**

i. For the purpose of this Policy, permissible ~~corporate securities~~**Corporate Securities** shall ~~have an~~ be rated in a **Rating Category** of "A" ~~rating category~~or its equivalent or better by ~~Moody's, Standard & Poor's, or Fitch Ratings Service~~an NRSRO and:

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

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

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

ii. Maximum Term:

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

i. Money Market Funds

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

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

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

j. **Joint Powers Authority Pool**

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

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

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

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

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

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

iv. Maximum Term:

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

k. Mortgage or Asset-backed Securities

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

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

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

a) Are rated AA~~- by a nationally recognized rating service; and~~ or better- or equivalent.

~~b) Are issued by an issuer having an "A" (Code), or better, rating by a nationally recognized rating service for its long-term debt.~~

iv. Maximum Term:

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

l. Variable and Floating Rate Securities

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

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

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

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

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

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

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

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

iii. Maximum Term:

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

m. Supranational Obligations

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

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

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

ii. Supranational obligations shall be rated in a **Rating Category** of "AA" or its equivalent or better by ~~two (2) of the three (3) largest nationally recognized rating services.~~ a Nationally Statistical Rating Organization (NRSRO).

iii. Maximum Term:

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

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section

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53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

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

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

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

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

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

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

b. Any one repurchase agreement counterparty name:

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

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

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a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum applies to all such securities backed by the same type of assets of the same issuer.

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

a. If ~~one (1)~~an **Investment Manager** exceeds the aforementioned diversification limits, the Investment Manager shall inform **CalOptima's Treasurer** and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

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

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

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

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

F. Maximum Stated Term

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

G. Rating Downgrades

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

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

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

H. Investment Restrictions

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

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

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

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

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

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

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

~~IV. ATTACHMENTS~~
IV. ATTACHMENT(S)

Not Applicable

~~V. REFERENCES~~
V. REFERENCE(S)

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

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

A. None to Date

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

~~A. 12/06/18: Regular Meeting of the CalOptima Investment Advisory Committee~~
~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors~~
~~C. 11/16/17: Regular Meeting of the CalOptima Finance Advisory Committee~~

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~~VIII.IV. REVISION HISTORY~~

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee
~~Date~~12/07/2017	~~Line(s) of Business~~Regular Meeting of the CalOptima Board of Directors
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee
12/06/2018	Regular Meeting of the CalOptima Board of Directors
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee

VIII. REVISION HISTORY

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

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IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; ~~and~~ and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, ~~risk~~Risk and return of a portfolio.

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Term	Definition
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working ~~capital~~Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of CalOptima's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Policy GA.3001: Board-Designated Reserve Funds; ~~or~~ or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet CalOptima's regulatory compliance requirements; or b. Currently defined as CalOptima's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.
Broker-Dealer	In financial services, a ~~broker-dealer~~Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Treasurer	Appointed by CalOptima's Board of Directors, the treasurer is a person responsible for overseeing CalOptima's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.

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Term	Definition
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The ~~risk~~Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Board of Directors with oversight responsibilities for all financial matters of CalOptima including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial ~~instrument~~Instrument or asset that can be traded. These assets can be cash, ~~bonds~~Bonds, or shares in a company
Investment ~~Advisors~~Advisor(s)	~~Members of CalOptima Investment Advisory Committee (IAC).~~Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding ~~the organization's investments.~~CalOptima's Investment Policies, Procedures and Practices..
Investment ~~Managers~~Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, ~~bonds~~Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.

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

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Term	Definition
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment ~~risk~~Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or ~~bonds~~Bonds of any of the fifty (50) U.S. states, including ~~bonds~~Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, ~~bonds~~Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including ~~bonds~~Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial ~~instrument~~Instrument or asset. CalOptima's asset managers provide CalOptima with reporting that shows the ~~valuation~~Valuation of each financial ~~instrument~~Instrument that they own on behalf of CalOptima. Each asset manager uses a variety of market sources to determine individual ~~valuations~~Valuations.

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Policy:	GA.3400
Title:	**Annual Investments**
Department:	CalOptima Administrative
Section:	Finance
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2018
Revised Date:	TBD

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I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

A. Delegation of Authority

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

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

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

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

B. **CalOptima Treasurer** Responsibilities

1. The **Treasurer** shall be responsible for:

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

b. The oversight of CalOptima's **Investment Portfolio**;

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

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

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

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

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

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

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

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

C. **Investment Advisory Committee**

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

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

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

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

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

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

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

D. Permitted Investments

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

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

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

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

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

2. Permitted investments shall include:

a. U.S. Treasuries

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

ii. U.S. Government securities include:

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

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

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

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

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

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

iv. Maximum Term:

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

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

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

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

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

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

k) Tennessee Valley Authority;

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l) Federal Agricultural Mortgage Company (FAMC);

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

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

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

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

c. **State and California Local Agency Obligations**

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

ii. Maximum Term:

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

d. Banker's Acceptances

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

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

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

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ii. Maximum Term:

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

e. **Commercial Paper (CP)**

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

a) **CP** of "prime" quality of the highest ranking or of the highest letter and number rating as provided for by a nationally recognized statistical rating organization (NRSRO);

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

(1) The entity meets the following criteria:

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

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

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

(2) The entity meets the following criteria:

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

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

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

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

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days

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Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 270 days 270 days	 270 days 270 days

f. **Negotiable Certificates of Deposit**

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

ii. Maximum Term:

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

g. **Repurchase Agreements**

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

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

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

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

d) The Agent will notify CalOptima's custodian and CalOptima if the **Valuation** of the **Collateral Securities** falls outside of policy. Upon direction by the **CalOptima Treasurer**, the Agent will liquidate the **Collateral Securities** if any deficiency in

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the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such **Valuation**.

ii. Maximum Term:

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

iii. Reverse **Repurchase Agreements** are not allowed.

h. **Corporate Securities**

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

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

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

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

ii. Maximum Term:

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

i. Money Market Funds

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

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

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

j. **Joint Powers Authority Pool**

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

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

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

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

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

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

iv. Maximum Term:

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

k. Mortgage or Asset-backed Securities

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

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

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

a) Are rated AA or better- or equivalent.

iv. Maximum Term:

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

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▪ Tier Two (2)	5 years stated final maturity	5 years

l. Variable and Floating Rate Securities

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

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

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

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

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

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

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

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

iii. Maximum Term:

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

m. Supranational Obligations

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

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

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

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

iii. Maximum Term:

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

n. Pooled Investments

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

E. Diversification Guidelines

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

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

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

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. **State and California Local Agency Obligations**	30% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	25% (Code)
F. **Negotiable Certificates of Deposit**	30% (Code)
G. **Repurchase Agreements**	100% (Code)
H. **Corporate Securities**	30% (Code)

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INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
I. Money Market Funds	20% (Code)
J. **Joint Powers Authority Pool**	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

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

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

   b. Any one repurchase agreement counterparty name:

      If maturity/term is ⩽ 7 days: 50%
      If maturity/term is > 7 days: 25%

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

   a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum applies to all such securities backed by the same type of assets of the same issuer.

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

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

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

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

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

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

F. Maximum Stated Term

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

G. Rating Downgrades

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

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

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

H. Investment Restrictions

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

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

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

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

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

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

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

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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

VI. REGULATORY AGENCY APPROVAL(S)

A. None to Date

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VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

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

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IX. GLOSSARY

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

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

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

FOR 2019 BOD REVIEW

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

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FOR 2019 12/5 BOD REVIEW

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Item

4. Consider Approval of CalOptima's Health Homes Program Policies

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

Approve CalOptima Policies and Procedures listed below to address Health Homes Program (HHP) implementation and requirements:

1. GG.1331: Health Homes Program Services and Care Management [Medi-Cal];
2. GG.1350: Health Homes Program Member Eligibility [Medi-Cal];
3. FF.4001: Special Payments: Health Homes Program Supplemental Payment for Capitated Health Networks [Medi-Cal]; which includes:
    a. Payment of a HHP Core Services Capitation Payment for HHP eligible and enrolled members and a separate Engagement Activities Supplemental Capitation Payment for HHP eligible members regardless of HHP enrollment.

Background

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option. The intent of HHP is to improve member outcomes and reduce health care costs. In California, Assembly Bill 361 (2013) authorizes implementation of the HHP. HHP, which is an entitlement benefit, is being implemented in selected California counties in a phased-in implementation approach, with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. On June 7, 2018, the CalOptima Board of Directors (Board) authorized an amendment to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) to incorporate implementation of the HHP. Implementation in Orange County is expected to be effective no sooner than January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and Substance Use Disorders (SUD), and no sooner than July 1, 2020, for CalOptima Medi-Cal members with eligible Serious Mental Illness (SMI).

For the first two years following implementation, the HHP will be funded by 90% federal funds and 10% from the California Endowment. Pursuant to Assembly Bill 361, for the first two years of the program, the HHP will not result in a net increase in ongoing General Fund costs for the Medi-Cal program, and no additional General Fund dollars will be used for program administration or services.

CalOptima received final rates for the HHP from DHCS on August 1, 2019. Staff projects $26.3 million in funding for the HHP over a three year period based on the enrollment assumptions provided by DHCS. At its June 6, 2019, meeting, the Board approved the CalOptima Fiscal Year (FY) 2019-20 Operating Budget, which included projected revenue and expenses for HHP for the period of January 1, 2020, through June 30, 2020.

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Pursuant to the DHCS Program Guide and All Plan Letter 18-012: Health Homes Program Requirements, MCPs will be responsible for overall administration, including the development of an HHP network. DHCS also published an HHP Program Guide that outlines the responsibilities of the MCPs and Community-Based Care Management Entities (CB-CMEs). Per DHCS requirements, HHP services are to be provided and coordinated through the network of CB-CMEs. In addition, CB-CMEs are responsible for coordinating care with members, providers and other agencies, as appropriate. The HHP Program Guide requires the following six core service categories for members enrolled in HHP:

- Comprehensive Care Management;
- Care Coordination;
- Health Promotion;
- Comprehensive Transitional Care;
- Individual and Family Support Services; and
- Referral to Community and Social Supports.

DHCS has also established HHP staffing requirements, which will be utilized across health networks, including:

- Clinical Consultant;
- HHP Director;
- Dedicated Care Coordinator;
- Housing Navigator for members experiencing homelessness; and
- Community Health Worker (recommended, but not required).

Discussion

Member Eligibility, Engagement and Enrollment in HHP

Members with certain chronic physical conditions, SUD or SMI, and meeting specified medical condition acuity requirements may qualify to participate in HHP. In order to participate, members must choose to enroll into HHP and not be required to change their primary care provider or health network. Based on DHCS eligibility criteria, CalOptima and its CB-CMEs plan to actively outreach to Medi-Cal only members potentially eligible for HHP and engage these members through written, telephonic, and face-to-face encounters to encourage member participation in the HHP. CalOptima anticipates that approximately 30,000 Medi-Cal only members will be potentially eligible for HHP, and that approximately 10% to 25% of these eligible members will elect to participate. HHP eligible members who are currently enrolled in the Whole Person Care pilot program may also elect to enroll in HHP. However, services provided under both programs cannot be duplicated. CalOptima's dually eligible members (i.e., those enrolled in both Medi-Cal and Medicare) can be referred to participate in HHP by community providers if members meet HHP eligibility criteria.

HHP CB-CME Network

In designing the CalOptima HHP CB-CME network, Management considered the DHCS requirements in context to the current delivery model. A primary requirement from the DHCS is that members must be able to participate in HHP without needing to change their health network or primary care provider. Approximately 80% of CalOptima members are assigned to a delegated health network, identified as a "physician group" in the DHCS HHP Program Guide. CalOptima's delegated health networks already have access to member information and have systems in place to support HHP activities. The health networks perform most of the care management activities required under health homes that focuses on a team approach that includes development and sharing of a health action plan, convening care team

meetings, transitional care, and updating the care teams when there is a change in the member's condition. HHP services would add incremental intensity to care management services provided by the health networks.

CalOptima also engaged an external vendor to conduct a survey of community-based organizations and community health centers to determine if these organizations provide HHP similar services. A total of 70 organizations were surveyed and 46 responded. The majority of the organizations can provide some but not all of the six HHP core service categories. If these organizations were used, CalOptima would need to build capacity to exchange member information and provide all HHP core services in threshold languages throughout the county. Engaging an organization other than the health networks presents challenges of potential duplication of services.

At implementation, CalOptima plans to leverage existing infrastructure to incorporate the new HHP services. CalOptima and its health networks will act as CB-CMEs for their assigned HHP eligible members and are expected to provide all HHP services, including housing support services and accompaniment for medical appointments. After implementation, CalOptima will consider opportunities to include additional providers for HHP services.

Payments to Delegated Health Networks acting as CB-CMEs
DHCS will provide Medi-Cal revenue to CalOptima for HHP services delivered to eligible and enrolled members. CalOptima will provide the health networks with a similar HHP specific capitation through an HHP Core Services Supplemental Capitation Payment for HHP services delivered to cover HHP core services to HHP eligible members who are enrolled in the HHP program. In addition, given that engagement of HHP eligible members is critical to the program's success, Management also recommends providing a separate reimbursement to the health networks through an Engagement Activities Supplemental Capitation Payment, which will be paid through CalOptima, for a member eligible but not enrolled in HHP. These supplemental capitation payments will be reported to DHCS in the rate development template as a medical or administrative expense, as allowable. Staff will report to DHCS on a regular basis the number of members who declined to participate in HHP or had an unsuccessful engagement.

Because the HHP is a new program, there is a possibility that rate development assumptions used by DHCS to calculate CalOptima's capitation rates may be materially different from actual utilization and expenses. Staff will closely monitor both utilization and expenses associated with the HHP and will continue to work with DHCS to ensure that Medi-Cal revenue is sufficient to support the program.

Implementation Efforts
Based on DHCS requirements and in partnership with the health networks, CalOptima staff continues to develop and adjust operational procedures and polices outlining HHP requirements, including member engagement and enrollment, care management, the CB-CME network and its responsibilities, staffing requirements and the MCP's oversight role. CalOptima will continue to submit deliverables to DHCS as required for HHP implementation.

Additionally, CalOptima staff will continue to partner and collaborate with the health networks, community partners and county agencies, especially the Orange County Health Care Agency, to coordinate behavioral health needs and services provided through the Whole Person Care pilot program.

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Policy and Procedures
The following attached CalOptima policies have been developed for HHP implementation:

A. ***GG.1331: Health Homes Program (HHP) Services and Care Management*** is a new policy that defines the HHP network and clinical delivery model to provide HHP services. It also includes guidelines and processes for outreach and engagement of HHP-eligible members, and CalOptima's expectations for CalOptima Direct and health networks, as CB-CMEs, to provide enhanced care management and care coordination to HHP enrolled members, including, but not limited to, office visit accompaniment, housing support services, and in-person care coordination, as needed.

B. ***GG.1350: Health Homes Program (HHP) Member Eligibility*** is a new policy that describes the process to identify Member eligibility for and prioritization for the CalOptima HHP. CalOptima staff developed this policy in accordance with state requirements for implementation of the Health Homes Program, effective January 1, 2020.

C. ***FF.4001: Special Payments: Health Homes Program Supplemental Payment for Capitated Health Networks*** is a new policy that defines the criteria for a health network to receive a supplemental payment for HHP services provided to an HHP-enrolled Medi-Cal member or a separate supplemental payment for engagement activities for members eligible but not enrolled in HHP, for dates of service on and after January 1, 2020. The policy specifically delineates HHP core services, in accordance with the Medi-Cal Health Homes Program Guide, issued by DHCS on November 1, 2019, and defines the two types of supplemental HHP payments available to health networks: (1) HHP Core Services Supplemental Capitation Payment and (2) Engagement Activities Supplemental Capitation Payment. The policy also describes the return of overpayments by health networks, adjustments to supplemental payment rates based on updates provided by DHCS, and procedures for a health network to file a complaint, if any.

Fiscal Impact
The recommended action to approve CalOptima's HHP policies and procedures has no additional anticipated fiscal impact in the current fiscal year beyond what was incorporated in the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. Considering that implementation in Orange County is expected to be effective no sooner than January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD, and no sooner than July 1, 2020, for CalOptima Medi-Cal members with eligible SMI, Management plans to include anticipated revenue and expenses for the HHP in the CalOptima FY 2020-21 Operating Budget and will keep the Board apprised of the financial performance of the program. Staff will also continue to work with DHCS to ensure CalOptima receives adequate funding through the first two years of the HHP following implementation.

Rationale for Recommendation
The recommended actions will enable CalOptima to operationally prepare for the anticipated implementation of HHP, effective no sooner than January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD, and no sooner than July 1, 2020, for members with eligible SMI.

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

Attachments
1. CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management [Medi-Cal]
2. CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility [Medi-Cal]
3. CalOptima Policy FF.4001: Special Payments: Health Homes Program Supplemental Payment for Capitated Health Networks [Medi-Cal]
4. Board Action dated October 3, 2019, Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program
5. Board Action dated October 3, 2019, Consider Authorizing Amendments to Medi-Cal Health Network Contracts Associated with AltaMed Health Services Corporation to include language for the Health Homes Program
6. Board Action dated October 3, 2019, Consider Authorizing Contract with Vendor for Health Homes Program Select Services for Accompaniment and Housing Related Services
7. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
8. Department of Health Care Services. Medi-Cal Health Homes Program, Program Guide 11/1/19
9. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

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Policy:	GG.1331
Title:	**Health Homes Program (HHP) Services and Care Management**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2020
Revised Date:	Not Applicable

FOR 20191205BOD REVIEW

I. PURPOSE

This policy defines CalOptima's **Health Homes Program (HHP)*** guidelines and processes for outreach and engagement of **HHP**-eligible **Members** and enhanced care management and care coordination approach to **HHP**-enrolled **Members**, including, but not limited to, office visit accompaniment, housing support services, and in-person care coordination.

II. POLICY

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A. As an **HHP**-participating Medi-Cal managed care plan, CalOptima is responsible for the overall administration of the **HHP** including:

1. Improving **Member** outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based **Long-Term Services and Supports** (**LTSS**), oral health services, **Palliative Care**, and social support needs; and

2. Reducing avoidable health care costs, including hospital admissions/readmissions, emergency department visits, and nursing facility stays.

B. CalOptima shall implement the **HHP** in two (2) phases, as prescribed by the Department of Health Care Services (DHCS):

1. No sooner than January 1, 2020: For **HHP Members** with eligible chronic physical conditions and substance use disorders; and

2. No sooner than July 1, 2020: For **HHP Members** with eligible serious mental illness conditions.

C. CalOptima shall select **Community-Based Care Management Entities (CB-CMEs)** in accordance with Welfare and Institutions Code Section 14127.3(d)(1) and the **CB-CME** qualifications as defined by DHCS in the **HHP** Program Guide, which are set forth in Attachment B of this policy. CalOptima shall develop an **HHP** network that includes:

1. All contracted **Health Network**s to serve as a **CB-CME** for their assigned **Members**; and

2. **CalOptima Direct (COD)** to serve as a **CB-CME** for **Members** assigned to **CalOptima Direct**.

D. CalOptima and **CB-CMEs** shall ensure compliance with all applicable State and federal requirements related to **HHP** and all **HHP** requirements determined by DHCS, including but not

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

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limited to DHCS All Plan Letter (APL) 18-012: Health Homes Program Requirements and the **HHP** Program Guide.

E. CalOptima shall ensure an **HHP** structure that will enable a **CB-CME** to provide six (6) core **HHP** services to assigned **HHP Members**:

1. Comprehensive care management;

2. Care coordination;

3. Health promotion;

4. Comprehensive transitional care;

5. Individual and family support services; and

6. Referrals to community and social supports.

F. CalOptima **Member** eligibility for participation in the **HHP** shall be determined in accordance with CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility.

G. CalOptima shall conduct targeted, progressive engagement attempts to **Members** on the Finalized Engagement List (**FEL**). **Members** interested in knowing more about and/or participating in **HHP** will be transferred to their assigned **CB-CME** for **HHP** information and possible program enrollment.

H. **CB-CMEs** shall utilize a team approach consisting of **HHP** multi-disciplinary care teams ("**HHP Care Team**s"), as described in Section III.A. of this policy, which are overseen by an **HHP** Director at each **CB-CME**.

I. CalOptima and the **CB-CMEs** shall complete a **Member Health Needs Assessment** (**HNA**), conduct a multidisciplinary case conference by the **HHP Care Team** as described in Section III.A of this policy, and create a **Health Action Plan** (**HAP**) for each **HHP Member**.

1. The **HAP** will be reassessed at regular intervals and when changes occur in the **Member**'s progress or status and health care needs.

2. CalOptima and **CB-CMEs** shall ensure **HHP Member HNA**s are available to the primary care providers (PCPs), mental health service providers, substance use disorder services providers, and **HHP Care Team** care coordinators for all **HHP Members**.

J. **CB-CMEs** shall be responsible for coordinating with **HHP Members**, existing providers and other agencies, including CBOs, in order to serve as the central point of contact of patient-centered care for **HHP Members**.

K. CalOptima and a **CB-CME** shall ensure ongoing care coordination, including discharge planning, as necessary, in accordance with this policy and CalOptima Policies GG.1301: Comprehensive Care Management Process and GG.1308: Monitoring Health Network Compliance via Case Management Reports.

L. **CB-CMEs** shall establish, as necessary, contractual relationships with CBOs or other organizations to provide **HHP Members** with **HHP** services, and contractual or non-contractual relationships

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with CBOs to provide linkages to community and social support services. **CB-CMEs** may contract for select services, such as office visit accompaniment and housing support services.

M. CalOptima will provide the **CB-CMEs** with information on admissions and discharges and ensure timely follow-up care.

N. CalOptima shall provide training prior to administration of the **HHP** as well as ongoing training to participating **CB-CME** care management staff members. Training shall encompass **HHP** program overview, **HAP**, care coordination, and care transitions within the **HHP**, community resources and referrals, as well as operational and condition-specific trainings. In addition, CalOptima will provide training on special populations, social determinants of health, motivational interviewing, trauma-informed care, health literacy assessment, and information sharing.

O. CalOptima's Case Management Department shall conduct strong oversight of the **CB-CMEs** by performing regular monitoring and auditing activities to ensure that case conferences occur, the **HAP** is updated as health care events occur, and all other **HHP** care management requirements are completed. CalOptima shall provide regular feedback and reporting of oversight results to the **CB-CMEs** as described in Section III.G. of this policy. CalOptima's oversight of the **CB-CMEs** shall also include, but not be limited to, the monitoring and auditing activities described in CalOptima Policy GG.1308: Monitoring **Health Network** Compliance via Case Management Reports.

P. CalOptima shall use medical management and data warehouse systems to support prioritization and risk stratification of the **FEL** as well as additional **HHP**-eligible **Members** identified through other activities. In addition, **CalOptima Direct** and **CB-CMEs** shall use medical management and data warehouse systems to:

1. Record **HHP**-eligible **Members** referrals to **HHP**;
2. Record outreach attempts and **Member** decisions regarding enrolling in **HHP**;
3. Record responses to standardized **HNA** questions;
4. Provide repositories for care management data and **HNA** responses for reporting purposes;
5. Record **Member HAPs** based on needs and barriers identified during **HNA** information collection;
6. Record oversight data of **Member HAPs**;
7. Record and track care coordination activities provided by individual staff; including but not limited to managing care transitions;
8. Record and track referrals to community resources;
9. House authorization and utilization data; and
10. Store pertinent medical records and information.

Q. CalOptima and **CB-CMEs** shall establish and maintain a data-sharing agreement with other providers that is compliant with all federal and California state laws and regulations. If applicable laws and/or regulations require an **HHP Member's** valid authorization for release of his or her

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health information, CalOptima or a **CB-CME**, as applicable, may not release such information without the **HHP Member's** valid authorization.

III. PROCEDURE

A. HHP Care Teams

1. The **CB-CME** shall be responsible for **HHP Care Team** staffing, according to **HHP** required staffing ratios determined by DHCS.

2. The qualification and roles of the **HHP Care Team Members** are set forth in Attachment A of this policy. Except as otherwise stated below, the **HHP Care Team** shall include the following:

   a. Dedicated care coordinator;

   b. **HHP** Director;

   c. Clinical consultants;

   d. For **HHP Members** experiencing **Homeless**ness, a housing navigator; and

   e. Community health workers are recommended, but not required.

3. Additional team **Members**, such as a pharmacist or nutritionist, may be included on the **HHP** Care Team in order to meet the **HHP Member**'s individual care coordination needs.

4. CalOptima or a delegated **Health Network** serving as a **CB-CME**, as applicable, shall ensure that physical and/or behavioral health service providers who are not part of the **HHP Care Team** will cooperate and participate in **HAP** planning and coordination.

5. CalOptima or a **CB-CME** shall maintain a strong and direct connection to the **HHP Member**'s PCP and ensure the PCP's participation in **HAP** development and ongoing coordination.

B. CalOptima and the **CB-CME** will collaborate to make three (3) progressive attempts to engage **Members** who are included on the **FEL**.

1. CalOptima shall work collaboratively with its community partners, CBOs, and institutions where **Members** choose to receive services, as centers for strategic outreach and to share best practices. CalOptima's partnership with its associates include, but is not limited to, the following:

   a. Assistance in locating and contacting **Members**, as necessary.

   b. CalOptima shall create and share **HHP** materials that emphasize the benefits of the **HHP** for use with **Members**.

2. Progressive engagement of **HHP**-eligible **Members** may include mailed or other written communication, live calls, and in-person engagement:

   a. CalOptima shall provide early and ongoing outreach to **Members**, specifically for **Members** who may require additional encouragement or information to participate in **HHP**. Outreach and engagement with **Members** shall be culturally appropriate in accordance with

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CalOptima Policy DD.2002: Cultural and Linguistic Services, and meet health literacy standards and trauma-informed care standards.

b. **CB-CMEs** shall provide an **HHP** engagement notice to each **HHP**-eligible **Member** that describes the **HHP** and provides **CB-CME** contact information for interested **HHP**-eligible **Members**.

c. Outreach attempts shall include attempts to validate and update contact information if incorrect.

d. CalOptima Special Population PCCs shall visit local **Homeless** shelters weekly to engage **Members** experiencing **Homeless**ness who appear on the **FEL** or who are **HHP**-eligible based on CalOptima's data driven preliminary eligibility determination.

e. CalOptima shall evaluate **Members** who are identified through CalOptima's Homeless Response Team (HRT) for eligibility in **HHP**.

f. If **Members** are not able to be engaged after three (3) progressive attempts within ninety (90) calendar days of the initial outreach described in Section III.B.2.b. of this Policy, CalOptima or **CB-CME**, as applicable, shall notify the **Member**'s PCP and request that the PCP discuss the benefits of the **HHP** with the **Member** at the next visit. No further progressive engagement is required.

g. **Members** meeting **HHP** eligibility requirements must consent to **HHP** in order to participate. Consent may be oral or in writing and will be documented by the CB-CME's Customer Service staff or **HHP Care Team** staff prior to the **Member**'s participation in **HHP**.

h. **HHP Care Team Members** shall be available to an **HHP**-eligible and/or **HHP**-enrolled **Member** via telephone to answer questions and receive input about the **HHP**.

C. Outreach Expectations for **Members** Enrolled in **HHP**

1. Following enrollment into the **HHP**, **CB-CMEs** shall provide an initial welcome packet to each **HHP Member**.

2. **CB-CMEs** should encourage the enrolled **Members** to see their PCP within the sixty (60) calendars days following the **Member**'s enrollment date in **HHP**. In order to complete each **HHP Member**'s **HAP** within the ninety (90) calendar days following the **Member**'s enrollment date in **HHP**, **Members** shall receive contact, telephonic or written, from the **CB-CME**, including:

a. In-person contact will be prioritized, and is the preferred method of care coordination;

i. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled **Members** per quarter.

ii. More frequent in-person contacts are expected for **Members** in complex care management (Tier 1), based on the **Member**'s needs and preferences.

D. **HHP** Core Services

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1. Comprehensive Care Management

   a. Upon enrollment of the **Member** in the **HHP**, the **CB-CME** shall administer the DHCS-approved **HHP** Health Needs Assessment (**HNA**) to identify **Member** needs and barriers, and serve as the basis for the person-centered **HAP**.

      i. On an exception basis, such as a **Member** encountered by CalOptima during in-person outreach, CalOptima may conduct an **HNA** and assign the care management level, or tier, as part of the enrollment process and submit to the **CB-CME** for completion of the **HAP**.

   b. A **CB-CME** clinical consultant shall review and evaluate the responses to the **HNA** to assign or confirm a care management level as follows:

      i. Complex care management (Tier 1);

      ii. Care coordination care management (Tier 2); or

      iii. Basic care management (Tier 3).

   c. For **HNA**s collected by CalOptima, a CalOptima clinical consultant shall upload the **HNA**, care management level or tier level, and recommended interventions via secure FTP site to the **CB-CME** for consideration for inclusion in the **HAP**.

   d. A **CB-CME** care coordinator shall assist the **HHP Member** with development of the **HAP** and complete the **HAP** within ninety (90) calendar days of **HHP** enrollment.

   e. A **CB-CME** care coordinator shall provide comprehensive care management services to **HHP Members**, including, but not limited to the following:

      i. Assess and reassess **Members** as-needed for physical health, mental health, substance use, housing instability, **Member**'s perception of gaps in care, impacts related to social determinants of health, oral health care, **Palliative Care** needs, trauma-informed care needs, harm-reduction practices and social services needs;

      ii. Provide care management in accordance with CalOptima Policy GG.1301: Comprehensive Care Management;

      iii. Engage the **HHP Member** in the **HHP** and his or her own care;

      iv. Assess the **HHP Member**'s level of engagement and readiness for change using screenings and assessments with standardized tools;

      v. Coach the **HHP Member** in self-management skills;

      vi. Promote the **Member**'s self-management skills to increase their ability to engage with health and service providers;

      vii. Support the **Member** by working with them to achieve their self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines; and

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viii. Develop a **Member**'s **HAP** and revise it as appropriate;

ix. Ensure the needs identified on the **HHP HNA** and subsequent assessments are incorporated into the **Member's HAP**, in accordance with the **Member's** preferences;

x. Reassess a **Member**'s health status and goals;

xi. Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and

xii. Clarify roles and responsibilities of the multi-disciplinary team, providers, **Member** and family/support persons.

f. The **CB-CME** shall submit the **HNA**, **HAP**, and **HHP** tier assignment to CalOptima for oversight.

i. **CB-CME** shall use **HNA** and **HAP** formats as required by CalOptima.

2. Care Coordination

a. A **CB-CME** care coordination shall provide care coordination services to address the implementation of the **HAP** and ongoing care coordination, including but not limited to:

i. **Member** Support:

a) Work with the **HHP Member** to implement his or her **HAP**;

b) Assist the **HHP Member** with referrals to and navigation of physical health, oral health, behavioral health, **Palliative Care** services, social services, and housing supports;

c) Share options with the **HHP Member** for accessing care and providing information to the **HHP Member** regarding care planning;

d) Identify barriers to medication management and treatment plan adherence and work to overcome barriers;

e) Monitor and support treatment adherence (including medication management and reconciliation);

f) Assist in attainment of the **HHP** Member's goals as described in the **HAP**;

g) Encourage **HHP Member** engagement in decision making and continued participation in **HHP**; and

h) Ensure accompaniment of **HHP Members** to appointments, as needed.

ii. Coordination

a) Monitor and coordinate referrals and follow ups to ensure needed services and supports are offered and accessed;

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b) Share information with all involved parties to monitor the **Member**'s conditions, health status, care planning, medication usages and side effects;

c) Create and promote linkages to other services and supports, as needed;

d) Facilitate communication between **HHP Members** and healthcare providers to promote understanding;

e) Facilitate referral to other services and team **Members** as appropriate, including pharmacy, housing navigator, social services, health educator or health coach;

f) Maintain frequent, in-person contact with the **HHP Member** and care coordinator when delivering **HHP** services;

g) Strongly encourage the **HHP Member** to visit his or her PCP within sixty (60) calendar days of enrollment in **HHP**, assisting with coordination of this visit as appropriate;

h) Support screening, referral, and co-management of **HHP Members** with both behavioral and physical health conditions;

b. CalOptima or a **CB-CME**, as applicable, shall identify and take action to address an **HHP Member**'s gaps in care as follows:

i. Assess existing data sources for evidence of care appropriate to the **HHP Member**'s age and underlying chronic conditions, as appropriate;

ii. Evaluate the **HHP Member's** perception of gaps in care;

iii. Document gaps in care in the **HHP Member**'s case file, including evaluation of a **Member**'s perceptions of gaps in care;

iv. Document interventions in the **HAP** and progress notes;

v. Document findings from the **HHP Member's** response to interventions;

vi. Document discussions of **HHP Member's** care goals; and

vii. Document follow-up actions, and the person or organization responsible for follow-up.

3. Health Promotion

a. A **CB-CME** care coordinator shall refer the **HHP Member** or his or her family/support persons, to health education and disease management programs, as appropriate, for additional support and education regarding the **HHP Member's** health conditions in accordance with the **HHP Member**'s needs and preferences.

b. Health promotion services shall include, but are not limited to:

i. Encouraging and supporting health education for the **HHP Member** and family/support persons;

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ii. Assessing the **HHP Member** and family/support persons' understanding of the **Member**'s health condition and motivation to engage in self-management;

iii. Using evidence-based practices, such as motivational interviewing, to engage and help the **HHP Member** and family/support persons participate in and manage their care;

iv. Coaching **HHP Members** and family/support persons about chronic conditions and ways to manage health conditions, based on the **Member's** preferences; and

v. Linking the **HHP Member** and family/support persons with resources and programs such as:

a) Smoking cessation;

b) Self-help recovery resources;

c) Learning about and management of chronic conditions; and

d) Other services based on **Member** needs and preferences.

4. Comprehensive Transitional Care

a. A **CB-CME** care coordinator will assist the **HHP Member** with transitions between treatment settings, including admissions and discharges from the hospital, residential/treatment facility, out of an incarceration facility or other treatment centers as needed, including, but not limited to:

i. Facilitating medication reconciliation and information;

ii. Assisting with scheduling of timely follow up appointments after discharge with recommended outpatient providers and/or community partners;

iii. Assisting with development or implementation of appropriate discharge plan and a place to stay post-discharge such as temporary housing or stable housing and social services;

iv. Collaborating, communicating and coordinating the transition plan with all involved parties, including informing hospital discharge planners about **HHP**;

v. Easing the **HHP Member's** transition by ensuring the **HHP Member** has an understanding of their post-transition self-management, medication management and rehabilitation activities, as appropriate;

vi. Preventing and tracking avoidable admissions and readmissions;

vii. Facilitating transportation for transitional care, including to medical appointments, in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical;

viii. Evaluating need to revise the **HHP Member's HAP**;

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ix. Working with the **HHP Member** to assess understanding of discharge plan and assisting the **Member** with engaging with and implementing discharge plan; and

x. Providing housing navigation and support services, as appropriate, including:

a) Temporary housing or stable housing and social services; and

b) Transition support to permanent housing.

b. In order to prevent and track avoidable admissions and readmissions, an **HHP Member**'s care coordinator is notified about **HHP Member** transitions through the **CB-CME**'s existing medical management/data systems and as required by CalOptima Policy GG.1500: Authorization Instructions for **CalOptima Direct** and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals that require hospital notification to the **CB-CME** of emergency department visits, admissions and discharges.

5. Individual and Family Support Services

a. As part of the assessment and care management processes and with the overall goal of improving **Member** adherence to treatment and medication management, the **HHP** Care Team will:

i. Assess strengths and needs of the **HHP Member** and family/support persons, including support of caregivers, and readiness to receive information;

ii. Link the **HHP Member** and family/support persons to caregiver resources (*e.g.*, peer supports or support groups) to educate, motivate, and improve self-management;

iii. Connect the **HHP Member** to self-care programs to help increase their understanding of their conditions and care plan;

iv. Promote **HHP Member** and family/support persons in self-management and decision-making;

v. Determine when the **HHP Member** and family/support persons are ready to receive and act upon information provided and assist them with making informed decisions;

vi. Advocate for the **Member** and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals;

vii. Arrange accompaniment to critical appointments, as appropriate;

viii. Identify barriers to improving adherence; and

ix. Evaluate family/support persons' needs for services.

6. Referral to Community and Social Supports

a. As part of the assessment and care management processes, the **HHP Care Team** will:

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i. Identify the **Member**'s community and social support needs and preferences and available resources to meet such needs;

ii. Identify resources and eligibility criteria for housing, food security and nutrition, employment counseling, childcare, community-based **LTSS**, school and faith-based services, and disability services, as needed and desired by the **Member**;

iii. Actively engage appropriate referrals to the needed resources, access to care, and engagement with other community and social supports;

iv. Provide the **Member** with information about and referrals to community resources according to the **Member**'s needs and preferences;

v. Facilitate, coordinate, and follow up on resource referrals;

vi. Provide regular follow up, via in-person or telephonic contacts, to support **Member** engagement with resources;

vii. Provide **Individual Housing Transition Services**; and

viii. Provide **Individual Housing and Tenancy Sustaining Services**.

E. Housing Support Services

1. CalOptima and the **CB-CME** will work with CBOs and vendors who specialize in housing assistance services and local shelters to ensure seamless access to the delivery of housing support services. The **HHP** does not provide direct funding for housing.

2. To the extent applicable, housing-based case management services provided by CalOptima, the **CB-CME**, CBOs and vendors to **HHP Members** shall be consistent with the Housing First core components as described in Welfare and Institutions Code Section 8255, specifically:

   a. Engagement to **Members** potentially eligible for **HHP** or the provision of **HHP** housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for **HHP** or meet one (1) or more of the DHCS defined **HHP** exclusionary criteria as described in CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility.

   b. **HHP** housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of **Members'** lives, where **Members** are engaged in nonjudgmental communication regarding drug and alcohol use.

   c. **Members** will be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

3. A **CB-CME** shall staff directly or contract with a vendor to provide housing support services for **Members** experiencing homelessness.

4. A housing navigator, a required role of the **HHP Care Team**, for **HHP Members** experiencing homelessness will use Housing First principles and components to provide the following services:

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a. **Individual Housing Transition Services**

i. Conducting a tenant screening and housing assessment, such as the **Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT)**, that identifies the **Member's** preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;

ii. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the **Member's** approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;

iii. Assisting with the housing application process and with the housing search process;

iv. Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;

v. Ensuring that the living environment is safe and ready for move-in;

vi. Assisting in arranging for and supporting the details of the move; and

vii. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

b. **Individual Housing and Tenancy Sustaining Services**

i. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;

ii. Providing education and training on the roles, rights and responsibilities of the tenant and landlord;

iii. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;

iv. Providing assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;

v. Providing advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;

vi. Providing assistance with the housing recertification process;

vii. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and

viii. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

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5. A **CB-CME** housing navigator shall assist **Members** experiencing homelessness with the completion of the **VI-SPDAT** to determine risk and prioritization of housing services, as appropriate.

F. The **Member's CB-CME**, or CalOptima for a **Member** assigned to **COD**, shall accept referrals of potentially **HHP**-eligible **Members** from providers, which shall include the **HHP** eligibility criteria and the **Member**'s interest in participating in **HHP**. For purpose of this section only, the term "provider" includes PCPs, Specialists, Community-Based Organizations, Whole-Person Care providers, and any other providers that are currently treating potentially **HHP**-eligible **Members**.

1. The **CB-CME** shall evaluate and provide verification of **Member** eligibility for the **HHP** to CalOptima's Case Management Department for final confirmation via facsimile or other means as directed by CalOptima.

   a. CalOptima's Case Management Department shall provide final confirmation to the **CB-CME** via facsimile, CalOptima's medical management systems, or other means as directed by CalOptima regarding the **Member**'s **HHP** eligibility within five (5) business days.

2. **Members** referred for the **HHP**, as well as the referring provider, shall be notified by the **CB-CME** of the **Member**'s eligibility or ineligibility for the **HHP** within five (5) business days of receipt of final confirmation from CalOptima as described in Section III.F.1.a. of this Policy.

3. **Members** who are not eligible for the **HHP** will be offered other supportive programs available to them by the **CB-CME**.

G. Health Homes Program Care Management Oversight Responsibilities

1. **CB-CME HHP** Director shall have:

   a. Overall responsibility for the management and operations of the **HHP Care Team**; and

   b. Responsibility for quality measures and reporting for the **HHP Care Team**.

2. Upon completion of the **HAP**, the **CB-CME** clinical consultant shall review the **HAP** for:

   a. Completeness and accuracy of information provided;

   b. Clinical data;

   c. Implementation progress and update as events unfold; and

   d. Transmit the **HNA**, **HAP**, and care management level (Tier) to CalOptima.

3. A CalOptima clinical consultant shall review the **CB-CME's** returned completed **HNA** and **HAP** and shall evaluate:

   a. Completeness and accuracy of information provided;

   b. Clinical data; and

   c. Implementation progress.

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4. On a daily basis, a CalOptima clinical consultant shall communicate any deficiencies to the **CB-CME**.

5. The CalOptima clinical consultant shall perform regular monitoring to ensure that:

    a. Case conferences occur;

    b. **HAP** is updated as health care events unfolds; and

    c. All other **HHP** care management requirements are completed.

6. On a monthly basis, CalOptima shall provide feedback in aggregate form to the **CB-CME**.

7. CalOptima shall ensure overall oversight of **CB-CMEs** in accordance with CalOptima Policy GG.1619: Delegation Oversight.

8. Clinical Support for Care Coordination

    a. A **CB-CME** clinical consultant or care coordinator shall:

        i. Be available as a clinical resource for care coordination, as needed; and

        ii. Facilitate access to primary care, including advising the **Member**'s PCP of referrals to other agencies, including **LTSS** and behavioral health providers, in accordance with CalOptima Policy GG.1301: Comprehensive Care Management as needed to assist in care coordination.

IV. ATTACHMENTS

A. Multi-Disciplinary Care Team Qualifications and Roles
B. Community Based-Care Management Entity (CB-CME) Qualifications

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C.
D. CalOptima Policy GG.1301: Comprehensive Care Management
E. CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports
F. CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility and Enrollment
G. CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
J. CalOptima Policy GG.1619: Delegation Oversight
K. Welfare and Institutions Code §§ 14127-14128
L. Health and Safety Code §§ 50675.2 and 50675.14
M. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements
N. Department of Health Care Services Medi-Cal Health Homes Program Guide (11/01/2019)

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VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

Date	Meeting

VIII. REVIEW/REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2020	GG.1331	Care Management - Health Homes Program	Medi-Cal

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IX. GLOSSARY

Term	Definition
CalOptima Direct (COD):	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Chronically Homeless Member	A Member with a condition limiting the activities of daily living and who has been continually Homeless for one (1) year or more or had at least four (4) episodes of Homelessness in the past three (3) years. For the purposes of this policy, a Member who is currently residing in transitional housing (as defined in Health and Safety Code section 50675.2) or who has been residing in permanent supportive housing (as defined in Health and Safety Code section 50675.14) for less than two (2) years shall also be considered Chronically Homeless if the Member was Chronically Homeless prior to residence.
Community Based-Care Management Entities (CB-CME)	Providers within the community that have a contractual relationship with CalOptima, or CalOptima acting directly, to provide HHP services to HHP Members.
Finalized Engagement List (FEL)	The list to include the DHCS TEL and CalOptima Member data created by applying risk stratification criteria for CalOptima and CB-CMEs to utilize for Member engagement activities.
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 Action Plan (HAP)	A comprehensive individualized care plan with the inclusion of any elements specific to HHP.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP services that provide supplemental services to HHP eligible and enrolled Members coordinating the full range of physical health, behavioral health, and community-based LTSS needed for chronic conditions.
HHP Care Team	The HHP Care Team includes Care Coordinators , a CB-CME HHP Director, Clinical Consultants, a housing navigator (for HHP enrolled Members experiencing Homelessness), and community health workers (recommended, but not required).
HHP Member	A Member who is enrolled, and continuously participating in the CalOptima Health Homes Program, and assigned to a Health Network or CalOptima Direct.
Health Needs Assessment	The assessment CalOptima uses as a health risk assessment for HHP-eligible Members.
Homeless	A Member who, as stated fully in 24 C.F.R. section 91.5, lacks a fixed, regular, and adequate nighttime residence, or who will imminently lose their primary nighttime residence; or are an unaccompanied Member under twenty-five (25) years of age; or a Member who is fleeing dangerous or life-threatening conditions, has no other residence, and lacks the resources to obtain permanent housing.

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Term	Definition
Individual Care Plan (ICP)	A written plan of care developed after an assessment of a Member's social and health care needs that reflects what services the Member will receive to reach and keep his or her best physical, mental, and social well-being.
Individual Housing Transition Services	Services that support a Member's ability to prepare for and transition to housing and are further described in the Center for Medicaid & CHIP Services (CMCS) informational bulletin titled, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," dated June 26, 2015.
Individual Housing & Tenancy Sustaining Services	Services that support Members in being successful tenants in their housing arrangement, thus able to sustain tenancy, and are further described in the Center for Medicaid & CHIP Services (CMCS) informational bulletin titled "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," dated June 26, 2015.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all the following: 1. Community-Based Adult Services (CBAS); 2. In-Home Supportive Services (IHSS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.
Member	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.
Notice of Action	Written notice informing a Member of an adverse benefit determination.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
Targeted Case Management	Specialized case management services for Medi-Cal eligible individuals in a defined target population to gain access to needed medical, social, educational, and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.
Targeted Engagement List (TEL)	The lists developed by DHCS of Medi-Cal Members who 1) appear to meet the HHP eligibility criteria based on Member characteristics identified in DHCS administrative data; and 2) are to be considered by CalOptima for engagement.
Well-Managed	Members with HHP chronic conditions that (a) do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation or (b) are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, that determines that the Member's eligible chronic conditions are already Well-Managed – to the extent that HHP services are not medically necessary and will not significantly change the Member's health status. This includes participation in other CalOptima programs that are not Medicaid-funded that may be available and for which the Member is eligible.

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Term	Definition
Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT)	A survey administered both to individuals and families to determine risk and prioritization when providing assistance to Homeless and at-risk of Homelessness persons.

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Attachment A

Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within CalOptima or CB-CME guidelines, as applicable • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to CalOptima or CB-CME guidelines, as applicable • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or CalOptima)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

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Attachment A

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within CalOptima or CB-CME guidelines, as applicable • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

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Attachment B

Community Based-Care Management Entity (CB-CME) Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with California Welfare and Institutions Code Health Homes Program (HHP) requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by CalOptima, according to the CB-CME contract with CalOptima;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and CalOptima and other providers involved in the HHP member's care.

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Policy:	GG.1350
Title:	**Health Homes Program (HHP) Member Eligibility**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2020
Revised Date:	Not Applicable

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I. PURPOSE

This policy describes the process to identify **Member*** eligibility for and prioritization for the CalOptima **Health Homes Program (HHP).**

II. POLICY

A. CalOptima shall implement the **HHP** in two (2) phases, as prescribed by the Department of Health Care Services (DHCS):

1. No sooner than January 1, 2020: For **HHP Members** with eligible chronic physical conditions and substance use disorders; and

2. No sooner than July 1, 2020: For **HHP Members** with eligible serious mental illness conditions.

B. CalOptima shall conduct targeted, progressive outreach during the first eighteen (18) months after the implementation of the **HHP** in accordance with CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management.

1. CalOptima shall evaluate and finalize the list of **Members** meeting **HHP** eligibility criteria for engagement activities by analyzing the **Targeted Engagement List (TEL)**, as provided by DHCS, incorporating Member data from CalOptima's data warehouse to develop a **Finalized Engagement List (FEL)**.

   a. CalOptima and **Community Based Care Management Entities (CB-CMEs)** will coordinate to ensure that **Members** who meet exclusionary criteria are excluded or disenrolled from the **HHP** pursuant to the **HHP** Program Guide and Sections III.A.1.b. and c. of this Policy.

   b. CalOptima shall prioritize **HHP**-eligible **Members** to identify those **Members** most likely to benefit from the **HHP** and who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. CalOptima shall make available a specific **FEL** identifying **HHP**-eligible **Members** to each **CB-CME** for their assigned **Members**. CalOptima will update the **FEL** at least every six (6) months upon receipt of the **TEL** from DHCS.

C. CalOptima shall provide training prior to administration of the **HHP** as well as ongoing training to participating **CB-CME** care management staff members. Training shall encompass **HHP** program overview, **Health Action Plans (HAP)**, care coordination, and care transitions within the **HHP**, community resources and referrals, as well as operational and condition-specific trainings. In addition, CalOptima will provide training on special populations, social determinants of health,

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

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motivational interviewing, trauma-informed care, health literacy assessment, and information sharing.

D. CalOptima and **CB-CMEs** shall conduct outreach, engagement and care coordination activities for **HHP**-eligible **Members** in accordance with CalOptima Policy GG.1331: Health Homes Program Services and Care Management.

E. CalOptima shall conduct oversight of the **CB-CMEs** to ensure that the **CB-CMEs** have implemented and continuously meet the **HHP** requirements, policies and operational processes, including outreach, engagement, and care management functions. CalOptima shall provide regular feedback and reporting of oversight results as described in CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management.

F. CalOptima and **CB-CMEs** shall use medical management and data warehouse systems to:

1. Record **HHP**-eligible **Members** referrals to **HHP**; and

2. Record outreach attempts and **Member** decisions regarding enrolling in **HHP**.

G. CalOptima and **CB-CMEs** shall ensure compliance with all applicable State and federal requirements related to HHP and all HHP requirements determined by DHCS, including but not limited to DHCS All Plan Letter (APL) 18-012: Health Homes Program Requirements and the **HHP** Program Guide.

III. PROCEDURE

A. Eligibility

1. To be eligible for **HHP**, a CalOptima **Member** must be full-scope Medi-Cal, have no share of cost, meet the following eligibility criteria in subsection a. below and not be excluded per the criteria in subsection b. below:

a. **HHP Member** eligibility criteria:

i. Chronic condition criteria: Member must meet at least one (1) condition category below:

a) At least two (2) of the following: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic kidney disease, chronic liver disease, dementia, or substance use disorders; or

b) Hypertension, and one (1) of the following: chronic obstructive pulmonary disease, diabetes, coronary artery disease, or chronic or congestive heart failure; or

c) Asthma; or

d) One (1) of the following: major depression disorders, bipolar disorder, or psychotic disorders (including schizophrenia).

ii. Acuity criteria: **Member** meets at least one (1) acuity criteria below:

a) Has three (3) or more of the **HHP**-eligible chronic conditions; or

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b) Has at least one inpatient hospital stay in the last year; or

c) Has visited the emergency department three (3) or more times in the last year; or

d) Is **Chronically Homeless**.

b. **HHP Member** eligibility exclusions:

i. **Members** meeting the following criteria shall be excluded from the **HHP** and, if enrolled, must be disenrolled:

a) **Members** determined through further assessment to be sufficiently **Well-Managed** through self-management or through another program, or the **Member** is otherwise determined not to fit the high-risk eligibility criteria;

b) **Members** whose condition management cannot be improved because the Member is uncooperative;

c) **Members** whose behavior or environment is unsafe for **CB-CME** staff; or

d) **Members** determined to be more appropriate for an alternate care management program.

ii. CalOptima shall screen **Members** to ensure that **Members** participating in any of the following programs are excluded from the **FEL** as these **Members** cannot participate in **HHP**:

a) Skilled Nursing Facility residents with a duration of stay longer than the month of admission and the following month; or

b) Hospice recipients.

iii. CalOptima and the **CB-CME** shall screen **Members** to ensure non-duplication of care coordination services by allowing **Members** who are enrolled in any of the following programs to choose whether to enroll in **HHP** or continue with their current services:

a) County-operated **Targeted Case Management (TCM)**, excluding Specialty Mental Health TCM; or,

b) 1915(c) Home and Community Based Services (HCBS) Waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH); or,

c) Program of All-Inclusive Care for the Elderly (PACE); or

d) Cal Medi-Connect/OneCare Connect.

c. Disenrollment

i. If an **HHP**-eligible **Member** has or develops a condition that excludes him or her from **HHP**, or the **Member** cannot be engaged by CalOptima or the **CB-CME** within a

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specified period, or chooses not to participate, or fails to participate actively in **HHP** planning and coordination, CalOptima or the **CB-CME** will disenroll the **HHP**-eligible **Member** from the **HHP**.

ii. If determined by CalOptima or **CB-CME** that the **Member's** eligible chronic conditions have become **Well-Managed** to the extent that **HHP** services are not medically necessary and will not significantly change the **Member's** health status, CalOptima or **CB-CME** will disenroll the **Member** from **HHP**.

iii. CalOptima Direct or **CB-CME** shall send a **Notice of Action (NOA)** for **Members** disenrolled involuntarily from **HHP**. The requirement to send an **NOA** shall not apply in instances when an **HHP**-eligible **Member** chooses or agrees not to participate in **HHP**. An **HHP**-eligible **Member** who declines participation in **HHP** may later choose to participate in the **HHP**.

d. For **Members** who choose not to participate in **HHP**, CalOptima or a **CB-CME** shall close the **Member's** case in the **HHP** and offer the **Member** additional alternative care management services or referrals, as appropriate.

e. **Members** enrolled in Whole Person Care (WPC) may participate in **HHP**; however, there are services, such as care coordination, that can be provided only under **HHP**.

f. **Members** who are dually eligible or have End-Stage Renal Disease (ESRD) or are enrolled in a specific program such as California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Specialty Mental Health or Drug Medi-Cal can be referred to **HHP** and receive services through both **HHP** and their current program. CalOptima shall exclude these Members from the **FEL**.

g. **Members** meeting **HHP** eligibility requirements must consent to **HHP** in order to participate. Consent may be oral or in writing and will be documented by CalOptima's and **CB-CME's** Customer Service staff or **HHP Care Team** staff prior to **Member** participation in **HHP**.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services
B. CalOptima Policy GG.1206: Readability and Suitability of Written Health Education Materials
C. CalOptima Policy GG.1331 Health Homes Program Services and Care Management
D. Welfare and Institutions Code §§ 14127-14128
E. Health and Safety Code §§ 50675.2 and 50675.14
F. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements
G. Department of Health Care Services Medi-Cal Health Homes Program Guide (11/01/2019)

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VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2020	GG.1350	Health Homes Program (HHP) Member Eligibility	Medi-Cal

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IX. GLOSSARY

Term	Definition
Chronically Homeless Member	A Member with a condition limiting the activities of daily living and who has been continually Homeless for one (1) year or more or had at least four (4) episodes of homelessness in the past three (3) years. For the purposes of this policy, a Member who is currently residing in transitional housing (as defined in Health and Safety Code Section 50675.2) or who has been residing in permanent supportive housing (as defined in Health and Safety Code Section 50675.14) for less than two (2) years shall also be considered Chronically Homeless if the Member was Chronically Homeless prior to residence.
Community Based-Care Management Entities (CB-CME)	Providers within the community that have a contractual relationship with a CalOptima, or CalOptima acting directly, to provide HHP services to HHP Members.
Finalized Engagement List (FEL)	The list created from the DHCS TEL combined with CalOptima Member data after removal of members who meet data-based identifiable exclusion criteria. The FEL is prioritized for Member engagement activities and provided to CalOptima's CB-CMEs.
Health Action Plan (HAP)	A comprehensive individualized care plan with the inclusion of any elements specific to HHP.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP services that provide supplemental services to HHP eligible and enrolled Members coordinating the full range of physical health, behavioral health, and community-based LTSS needed for chronic conditions.
HHP Care Team	The HHP Care Team includes Care Coordinators, a CB-CME HHP Director, Clinical Consultants, a housing navigator (for HHP enrolled members experiencing homelessness), and community health workers (recommended, but not required).
HHP Member	A Member that is enrolled, and continuously participating in, CalOptima Health Homes Program, and assigned to a Health Network or CalOptima Direct.
Homeless	A Member who, as stated fully in 24 C.F.R. Section 91.5, lacks a fixed, regular, and adequate nighttime residence, or who will imminently lose their primary nighttime residence; or are an unaccompanied Member under twenty-five (25) years of age; or a Member who is fleeing dangerous or life-threatening conditions, has no other residence, and lacks the resources to obtain permanent housing.
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.
Notice of Action	Written notice informing a Member of an adverse benefit determination.
Targeted Case Management	Specialized case management services for Medi-Cal eligible individuals in a defined target population to gain access to needed medical, social, educational, and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.
Targeted Engagement List (TEL)	The lists developed by DHCS of Medi-Cal Members who 1) appear to meet the HHP eligibility criteria based on member characteristics identified in DHCS administrative data; and 2) are to be considered by CalOptima for engagement.

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Term	Definition
Well-Managed	Members with HHP chronic conditions that (a) do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation or (b) are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, that determines that the Member's eligible chronic conditions are already well-managed – to the extent that HHP services are not medically necessary and will not significantly change the Member's health status. This includes participation in other CalOptima programs that are not Medicaid-funded that may be available and for which the Member is eligible.

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Policy:	FF.4001
Title:	**Special Payments: Health Homes Program Supplemental Payment for Capitated Health Networks**
Department:	Finance
Section:	Accounting
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2020
Revised Date:	Not Applicable

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I. PURPOSE

This policy defines the criteria for a delegated **Health Network***, acting as a **Community-Based Care Management Entity (CB-CME)**, to receive a supplemental payment for **Health Homes Program (HHP)** services provided to an **HHP**-enrolled **Member** or a separate supplemental payment for engagement activities for a **Member** eligible but not enrolled in **HHP**.

II. POLICY

A. Effective for dates of service on and after January 1, 2020, CalOptima shall make the following supplemental payment to **Health Networks** acting as a **CB-CME** at rates set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy:

1. **HHP Core Services Supplemental Capitation Payment**; or

2. **Engagement Activities Supplemental Capitation Payment.**

B. CalOptima shall issue **HHP Core Services Supplemental Capitation Payment** at rates set forth in the **Contract for Health Care Services** when all of the following conditions are met:

1. **Member** is identified as an **HHP**-eligible **Member** as determined by CalOptima based on **HHP** eligibility criteria as defined by the **Department of Health Care Services (DHCS)** and in accordance with CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility; and

2. A Member is enrolled in **HHP**; and

3. A **Member** receives either one of the six (6) **HHP** core services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social supports; and

4. The **HHP** core services are billed and reported to CalOptima consistent with the most recent **HHP** Program Guide or specific regulatory guidance as directed by **DHCS**; and

5. If applicable, the **Health Network** paid the provider for the **HHP** core services; and

6. The **Health Network** authorized such **HHP** core services.

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

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C. If a Member is eligible but not enrolled in HHP, CalOptima shall issue an **Engagement Activities Supplemental Capitation Payment**, which is not otherwise covered by **HHP** under Sections II.B. and III.B.2. of this policy, at rates set forth in the **Contract for Health Care Services** when all the following conditions are met:

1. A **Member** is identified as an **HHP**-eligible **Member** as determined by CalOptima based on **HHP** eligibility criteria as defined by **DHCS** and in accordance with CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility; and

2. A **Member** is not enrolled in **HHP**; and

3. The **Health Network** conducted engagement activities to contact an **HHP**-eligible **Member** on CalOptima's **Finalized Engagement List** for enrollment in **HHP**; and

4. Engagement activities are billed and reported to CalOptima in a manner and form acceptable to CalOptima, including but not limited to identifying the non-enrollment status of the **HHP**-eligible **Member**; and

5. If applicable, the **Health Network** authorized and paid the provider for such engagement activities.

D. CalOptima staff shall ensure the **Engagement Activities Supplement Capitation Payment** set forth in Section II.C. of this policy are paid through CalOptima and not reported to **DHCS** for reimbursement.

E. CalOptima shall limit the provision of **Engagement Activities Supplemental Capitation Payment** as set forth in Section II.C. of this policy to a maximum of three (3) calendar months of billing per one (1) individual **HHP**-eligible **Member** who is not enrolled in **HHP**.

F. The **Health Network** shall submit the following:

1. **HHP Billing Data** for **HHP Core Services Supplemental Capitation Payment** as forth in Section II.B. of this policy through the CalOptima secure File Transfer Protocol (sFTP) site as per CalOptima's and **DHCS'** reporting requirements to CalOptima to process payments.

2. Engagement activities billing data for **Engagement Activities Supplemental Capitation Payment** as set forth in Section II.C. of this policy through the CalOptima sFTP site as per CalOptima's requirements to process payments and **DHCS'** reporting requirements on **HHP**-eligible **Member** that **Health Networks** seek to actively engage.

G. CalOptima shall issue either the **HHP Core Services Supplemental Capitation Payment** to the **Health Network** acting as a **CB-CME** or the **Engagement Activities Supplemental Capitation Payment** within thirty (30) business days from the date of the **HHP Billing Data** or engagement activities billing data submission, as applicable.

H. If a **Health Network** identifies an overpayment of the supplemental payment for **HHP** core services or engagement activities, the **Health Network** shall return the overpayment to CalOptima within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the overpayment.

1. CalOptima shall notify the **Health Network** of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

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2. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

I. In the event **DHCS** or CalOptima identifies that a **Member** was not eligible for **HHP**, CalOptima shall recover payments made to the **Health Network** for that **Member**. In the event **DHCS** or CalOptima identifies that a Member was not enrolled in **HHP**, CalOptima shall recover any **HHP Core Services Supplemental Capitation Payments** made to the **Health Network** for that **Member**.

J. CalOptima may adjust either the **Engagement Activities Supplemental Capitation Payment** or the **HHP Core Services Supplemental Capitation Payment** subject to **DHCS** funding updates.

III. PROCEDURE

A. CalOptima shall review and validate the following:

1. **HHP Billing Data** submitted by the **Health Network** on a monthly basis to determine if the conditions listed in Section II.B. of the policy are met; and

2. Engagement activities billing data submitted by the **Health Network** on a monthly basis to determine if the conditions listed in Section II.C. of the policy are met.

B. CalOptima shall review the **HHP Billing Data** and issue **HHP Core Services Supplemental Capitation Payment** for an **HHP**-eligible and **HHP**-enrolled **Member** who receives at least one (1) core **HHP** services in a calendar month in which the supplemental payment is requested by the **Health Network**, or the **Member** has received an **HHP** core service within one (1) of the prior two (2) calendar months in which the supplemental service month payment is requested by the **Health Network**.

C. CalOptima shall review the engagement activities billing data and issue **Engagement Activities Supplemental Capitation Payment** to a maximum of three (3) calendar months of billing per one (1) individual **HHP**-eligible **Member** who is not enrolled in **HHP**.

D. Upon the validation of the **HHP Billing Data** or engagement activities billing data, as applicable, the CalOptima Accounting Department shall issue the **HHP Core Services Supplemental Capitation Payment** or **Engagement Activities Supplemental Capitation Payment**, as applicable, to the **Health Network** within the timeframe described in Section II.G. of this policy. CalOptima shall provide remittance details to support the payment to **Health Networks** acting as a **CB-CME**. CalOptima and **Health Networks** shall follow the supplemental payment filing schedule below:

1. **Health Networks** shall submit **HHP Billing Data** and/or engagement activities billing data, as applicable, by the fifteenth (15th) calendar day after the month ends to the CalOptima secure File Transfer Protocol (sFTP) site. **Health Networks** shall submit **HHP Billing Data** and/or engagement activities billing data, as applicable, using CalOptima's proprietary format and file naming convention.

2. Upon request by CalOptima, the **Health Network** shall provide, within five (5) business days, detailed support for **HHP Billing Data** and/or engagement activities billing data, as applicable, to the CalOptima Business Integration Department.

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3. The CalOptima Business Integration Department shall notify the **Health Network** of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness or inconsistency issues. If CalOptima rejects a file, **Health Network** shall resubmit a corrected file no later than the fifteenth (15th) calendar day of the following month. Any resubmission after the fifteenth (15th) calendar day of the month will be included in the subsequent month's process.

4. For a complete **HHP Billing Data** and/or engagement activities billing data, as applicable, file accepted by CalOptima, CalOptima shall issue the **HHP Core Services Supplemental Capitation Payment** or **Engagement Activities Supplemental Capitation Payment**, as applicable, based upon the prior calendar month's **HHP Billing Data** or engagement activities billing data, as applicable, no later than the twentieth (20th) calendar day of the current month based upon prior month billing data.

5. If CalOptima receives the first submission and the second resubmission of a previously rejected file after the fifteenth (15th) calendar day of the month, either the **HHP Core Services Supplemental Capitation Payment** or the **Engagement Activities Supplemental Capitation Payment**, as applicable, will be included in the subsequent month's process.

E. A **Health Network** may file a complaint regarding CalOptima's **Engagement Activities Supplemental Capitation Payment** or **HHP Core Services Supplemental Capitation Payment** in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

F. CalOptima Contract for Health Care Services
G. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Policy GG.1350: Health Homes Program Member Eligibility
I. CalOptima Policy HH.1101: CalOptima Provider Complaint
J. Medi-Cal Health Homes Program Guide, Issued 11/01/2019

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2020	FF.4001	Special Payments: Health Homes Program Supplemental Payment for Capitated Health Networks	Medi-Cal

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IX. GLOSSARY

Term	Definition
Community Based-Care Management Entities (CB-CME)	Providers within the community that have a contractual relationship with CalOptima, or CalOptima acting directly, to provide HHP services to HHP Members.
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC), a physician group under a shared risk contract, or HMO, and DHCS Medi-Cal Managed Care Division Policy Letters.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Engagement Activities Supplemental Capitation Payment	The separate supplemental capitation payment that CalOptima provides to delegated Health Networks acting as a CB-CME for engagement activities for a Member who is HHP eligible and has not enrolled in the HHP.
Finalized Engagement List (FEL)	The list to include the DHCS TEL and CalOptima Member data created by applying risk stratification criteria for CalOptima and CB-CMEs to utilize for Member engagement activities.
HHP Billing Data	Report submitted monthly by a Health Network that contains qualified HHP services as defined by the DHCS Program Guide using CalOptima proprietary format and file naming convention.
HHP Core Services Supplemental Capitation Payment	The supplemental capitation that CalOptima provides to Health Networks acting as a CB-CME for qualifying HHP core services following a Member's enrollment in the HHP.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP services that provide supplemental services to HHP eligible and enrolled Members by coordinating and integrating the full range of physical health, behavioral health, and community-based LTSS needed for chronic conditions.
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 in 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 Medi-Cal program.
Targeted Engagement List (TEL)	The lists developed by DHCS of Medi-Cal Members who 1) appear to meet the HHP eligibility criteria based on member characteristics identified in DHCS administrative data; and 2) are to be considered by CalOptima for engagement.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to:
   a. Amend the CalOptima Medi-Cal Health Network Contracts, except those associated with AltaMed Health Services Corporation, to provide Health Homes Program (HHP) services, including responsibilities as Community Based-Care Management Entities (CB-CMEs), as well as include all subcontracting requirements of the California Department of Health Care Services (DHCS);
   b. Amend the Business Associate Agreements, as necessary, for network data sharing; and
2. Ratify the Behavioral Health Memorandum of Understanding (MOU) amendment with the Orange County Health Care Agency to reflect coordination of services for CalOptima members with mental health conditions who enroll in the Health Homes Program, effective October 1, 2019.

Background/Discussion

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option, which is intended to improve member outcomes and reduce health care costs with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. On June 7, 2018, the CalOptima Board of Directors authorized an amendment to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) to incorporate implementation of the HHP. Implementation in Orange County is expected to be effective no sooner than January 1, 2020 for CalOptima Medi-Cal members with eligible chronic physical conditions and substance use disorders (SUD), and no sooner than July 1, 2020 for CalOptima Medi-Cal members with Serious Mental Illness (SMI).

HHP Eligible Members and HHP Enrollment

Members with certain chronic physical conditions, SUD and SMI and meeting specified medical condition acuity requirements may qualify to participate in HHP. In order to participate, members must actively choose to enroll into HHP. Based on DHCS eligibility criteria, CalOptima staff plans to actively outreach to Medi-Cal only members potentially eligible for HHP and actively engage these members through written, telephonic, and face-to-face encounters to encourage member participation in HHP. CalOptima anticipates that approximately 30,000 Medi-Cal only members will be potentially eligible for HHP and that approximately 10% -25% of these eligible members will elect to participate. HHP eligible members who are currently in Whole Person Care Pilot program can also elect to enroll in HHP, however services provided under both programs cannot be duplicated. CalOptima's dually eligible

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members can be referred to participate in HHP by community providers if members meet HHP eligibility criteria.

HHP Network Delivery Model
In developing CalOptima's HHP strategy, staff has considered the impact of these new HHP requirements to CalOptima's current delivery system. The impact analysis has included reviewing staffing resources, process and system enhancements, data exchange, and available community resources for new HHP services, such as accompaniment to appointments, housing transition services and tenancy sustaining services. Many of the CB-CME responsibilities are currently being provided by CalOptima's health networks. For HHP, CalOptima can leverage existing infrastructure to incorporate the new HHP services.

HHP focuses on a small percentage of CalOptima's overall membership. Based on the member distribution of HHP enrollment projections within the health networks, CalOptima staff's initial recommended approach was to provide health networks with an option of participating in HHP; however, this approach would potentially have required members to change their health networks and/or primary care providers when enrolling in HHP. In January 2019, DHCS advised that CalOptima must adhere to HHP expectation of not requiring members to change their health networks and/or primary care providers in order to participate in the HHP. Consequently, CalOptima will require all health networks, including CalOptima Direct and CalOptima Community Network, to participate in HHP and meet CB-CME requirements. This approach will provide an adequate CB-CME network and ensure continuity of members' relationships with their respective health networks and primary care providers.

Health Network Contracts
In order to implement HHP, CalOptima health network contracts will need to be amended, effective January 1, 2020, to include providing HHP services, expectations of CB-CME responsibilities, guidelines for information and data sharing, as well as HHP training. Prior to implementing HHP, CalOptima will coordinate with the health networks regarding the development of infrastructure, policies and procedures, reporting capabilities, staffing ratio requirements, and the ability to deliver core services with added intensity and new select services, where appropriate.

Amendment to County Behavioral Health MOU
Pursuant to DHCS All Plan Letter 18-015: Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans, MCPs participating in HHP must coordinate care for members enrolled in HHP who also receive care through the Mental Health Plan (MHP or County). The MOU with the Orange County Health Care Agency is the vehicle for ensuring this coordination. The Behavioral Health MOU between CalOptima and the County of Orange has been amended to reflect that CalOptima and the County agree to coordinate appropriate services for CalOptima members with mental health conditions who are enrolled in HHP.

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Implementation Efforts
Based on DHCS feedback and in partnership with the health networks, CalOptima staff continues to develop and adjust operational procedures and polices outlining HHP requirements and operational processes impacting member engagement and enrollment, care management, CB-CME network and its responsibilities, staffing requirements and MCP oversight role. Currently, CalOptima's policies impacted by HHP requirements have been submitted to DHCS as part of the HHP regulatory submission requirements. Once CalOptima receives the feedback from DHCS, CalOptima staff will return to the Board with recommendations for approval of policy and procedures impacted by HHP requirements.

Additionally, CalOptima staff will continue to collaborate with Orange County HCA, Health Networks, and other stakeholders for Phase II of the Health Homes Program for SUD, SMI, and homelessness consistent with requirements as specified by DHCS.

Fiscal Impact
The anticipated implementation date for HHP in Orange County is January 1, 2020. Management has included projected revenues and expenses for HHP in the CalOptima Fiscal Year 2019-20 Operating Budget and will for future operating budgets. Total actual revenue and expenses for HHP will depend on the number of members that choose to participate in the program. Based on projected enrollment and draft rates received from DHCS on April 2, 2018, CalOptima is projected to receive $26.3 million in funding for HHP over a three-year period.

Since this is a new program for CalOptima, there is the possibility that the rate development assumptions applied by DHCS may be materially different from CalOptima's actual utilization and expenses. Staff will closely monitor both utilization and expenses and will continue to work with DHCS to ensure that Medi-Cal revenue will be sufficient to support the program.

Rationale for Recommendation
The recommended actions will enable CalOptima to operationally prepare for the anticipated implementation of Health Homes Program, effective January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD and July 1, 2020, for members with SMI.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
3. Department of Health Care Services. Medi-Cal Health Homes Program, Program Guide 7/1/19
4. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

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Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 14

Health Network	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CalOptima Community Network	505 City Parkway West	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Ave, #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

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- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

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	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

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A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
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www.dhcs.ca.gov

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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Medi-Cal Health Homes Program
Program Guide
7/01/19

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I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II. HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III. HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in <u>at least one</u> of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

Acuity Eligibility Criteria

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above. MCPs must have a process to verify eligibility as part of the enrollment process. MCPs can do this through reviews of the MCPs data and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

MCPs should make a preliminary eligibility determination based on their data prior to proceeding with proactive outreach and engagement. MCPs may rely on the TEL to verify that the member meets the eligibility criteria for having the eligible chronic conditions and the acuity criteria relating to having three or more of the eligible chronic conditions; however, the MCP should verify utilization acuity criteria (within 12 months) using the MCP's own data.

MCPs are required to review their own data for members who are on the TEL and should not proactively outreach members whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions. MCPs may also apply their own additional prioritization policies upon approval from DHCS.

At the point in time when the MCP makes this data-driven preliminary eligibility determination, the member will be considered eligible for the program regardless of how long it takes the member to agree to enroll. The member may be enrolled for at least one month to complete the member assessment and care plan process. If additional information is determined during the assessment/care plan process that negates prior eligibility data or confirms an exclusionary criteria, then the member will be disenrolled.

Homeless Eligibility Criteria

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section 50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her*

residence." For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

People Excluded from Targeted Engagement List

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
    1) Engage the member in the HHP and their own care
    2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
    3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
    4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
    1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
    2) How trauma-informed care best practices will be utilized?
    3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
    1) How the HAP is shared with other providers and if it can be shared electronically; and
    2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
    1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
    2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support

- Working with the member to implement their HAP
- Assisting the member in navigating health, behavioral health, and social services systems, including housing
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Identifying barriers to the member's treatment and medication management adherence
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Assisting in attainment of the member's goals as described in the HAP
- Encouraging the member's decision making and continued participation in HHP
- Accompanying members to appointments as needed

2) Coordination

- Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
- Creating and promoting linkages to other services and supports
- Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
    i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
    ii. Tier 1 – two in-person visits per month
    iii. Tier 2 – 1 in-person visit per month
    iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V. Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.
f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.
g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.
h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.
i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.
b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies
b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers
c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges
d. Track and share data with CB-CMEs regarding each member's health history
e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of

both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To

facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but

are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:

a. Letter to member followed by phone call to member
b. Phone call to member, outreach to care delivery partners and social service partners
c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities.

The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

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- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

SAMPLE

B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or
3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or
3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or
3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

- Nursing Facility Residents
- Hospice Recipients
- Members with TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or AHF
- Members in Cal MediConnect

b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

- Dually eligible members
- Members in CCS or GHPP
- Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Filler	Filler	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Filler	Filler	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

D. Appendix D – Readiness Requirements and Checklist

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI– MHP-MOU: Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

SMI Network: Section III – Network (Deliverables #6.2a and 6.2b)

Group	Counties	Deliverable Due Dates		Deliverable Approval Dates
Group 1	San Francisco	**P&Ps**:	3/1/18	5/1/18
		Network:	5/1/18	6/1/18
		SMI Deliverables:	11/1/18	12/1/18
Group 2	Riverside San Bernardino	**P&Ps**:	9/1/18	11/1/18
		Network:	11/1/18	12/1/18
		SMI MHP-MOU:	2/1/19	3/1/19
		SMI Network:	5/1/19	6/1/19
Group 3.1	Imperial Santa Clara	**P&Ps**:	1/1/19	5/1/19
		Network:	4/1/19	6/1/19
		SMI MHP-MOU:	7/1/19	8/1/19
		SMI Network:	10/1/19	12/1/19
Group 3.2	Alameda Kern Los Angeles Sacramento San Diego Tulare	**P&Ps**:	3/1/19	5/1/19
		Network:	5/1/19	6/1/19
		SMI MHP-MOU:	8/1/19	9/1/19
		SMI Network:	11/1/19	12/1/19
Group 4	Orange	**P&Ps**:	9/1/19	11/1/19
		Network:	11/1/19	12/1/19
		SMI MHP-MOU:	2/1/20	3/1/20
		SMI Network:	5/1/20	6/1/20

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.

For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.

When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.
   - Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.

- Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
- Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

5.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

5.2 Submit the Health Action Plan (HAP) template.

5.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:
- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – SMI**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members

with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

☐ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

☐ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

☐ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

☐ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

☐ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

☐ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

☐ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

☐ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

_____	_____
Managed Care Plan	Signature of Authorized Representative
_____	_____
Date	Name of Authorized Representative
	_____
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	**HCPCS Code**	**Modifier**	**Units of Service (UOS)**
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Telehealth and Group Visits

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

F. Appendix F – Evidence of Coverage Template

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• The three months of data must be combined into one figure to represent the quarter, with the exception of member level Homeless and Housing reports and annual reports.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. Member-level detail Homeless/Housing reports are due semi-annually, with the Q2 and Q4 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2 and Member-level Homeless/Housing – April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4 and Member-level Homeless/Housing – October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx

[MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

All report revisions are subject to DHCS review and approval.

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx. to your designated folder in the "DHCS-MCQMD-Data/MCP" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Homeless and Chronically Homeless: see CA Welfare & Institution Code § 14127(e)

Housing Services:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

1. Health Home Program Enrollment Reporting	
***Note:* Only report one (1) exclusionary reason per member excluded from the Program.**	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number MCP excluded because not eligible - well-managed (Column C)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.
Number MCP excluded because declined to participate (Column D)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP.
Number MCP excluded because of unsuccessful engagement (Column E)	Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment.

Number MCP excluded because duplicative program (Column F)	Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following: 1. Duplicative Programs a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH) b. Targeted Case Management (TCM) – County, not Mental Health TCM 2. Programs excluded by DHCS Policy a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month. b. Hospice 3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy
Number MCP excluded because unsafe behavior or environment (Column G)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)	Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following: a. Fee-For-Service b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF) c. Member is deceased
Number externally referred & enrolled (Column I)	Enter the number of members not part of the plan's targeted engagement process, referred to the MCP, that were enrolled. The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Upon MCP review and evaluation, if the individual is approved for HHP and enrolled, they would be included in this measure. If they are not approved for enrollment in HHP, they would be reported in the following measure.
Number externally referred but excluded (Column J)	Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H.
Average monthly number of dedicated care coordination FTEs (Column K)	Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number.
2. Health Home Program Member Activity Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number initial HAP completed within 90 days (Column C)	Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment.
Number initial HAP completed (Column D)	Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter.

3. Health Home Program Homeless/Housing Member Level Detail	
Note: This tab is to be submitted semi-annually in the Q2 report and Q4 report of every year. The Q2 report (due 8/31) will include data for January through June of the current calendar year. The Q4 Report (due 2/28) will include data for July through December of the previous calendar year.	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and semi-annual reporting period. For example, the second reporting period of 2019 will be entered as 2019 Q3-Q4.
Member CIN (Column C)	Enter the Member's Client Identification Number (CIN) for all members that meet Column G and/or Column I.
Member Last Name (Column D)	Enter the Member's Last Name.
Member First Name (Column E)	Enter the Member's First Name.
Member Date of Birth (DOB) (Column F)	Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY.
Homeless HHP Members and HHP Members at Risk for Homelessness During This Reporting Period (Column G)	Indicate whether the HHP enrolled member met the Federal definition of Homeless or required tenancy sustaining services at any point during the reporting period. Enter "Yes" or "No."
Received Housing Services During This Reporting Period (Column H)	Indicate whether the HHP enrolled member received housing services at any point during the reporting period. Enter "Yes" or "No."
Homeless Health Homes Members In Any Enrollment Period (Column I)	Indicate whether the HHP enrolled member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No."

HHP Members who are no longer Homeless On Last Day of This Reporting Period (Column J)	Indicate the HHP enrolled member no longer meets the Federal definition of Homeless, as of the last day of the reporting period. If the member was disenrolled during the reporting period, report as of their last date of enrollment. Enter "Yes" or "No."
4. Health Home Program Network Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
CB-CME NPI # (Column C)	Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors.
Capacity for each CB-CME (Column D)	Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter.
5. Health Home Program Annual CMS Core Measures Reporting	

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the Technical Specifications and Resource Manual link from CMS. Approve the license agreements and download the Technical Specifications.

https://www.medicaid.gov/license-agreement.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-home-information-resource-center%2Fdownloads%2FFFY-18-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The Technical Specifications require reporting results when the SPA is in effect for six or more months of the measurement period. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

Note: **This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year for the data reported: Year.
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator

CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - numerator (Column M)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator

CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CDF (MED) - Age 12-17 - numerator (Column W)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - numerator
CDF (MED) - Age 12-17 - denominator (Column X)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - denominator
CDF (MED) - Age 18-64 - numerator (Column Y)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - numerator
CDF (MED) - Age 18-64 - denominator (Column Z)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - denominator
CDF (MED) - Age 65+ - numerator (Column AA)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - numerator
CDF (MED) - Age 65+ - denominator (Column AB)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - denominator
CDF (SMI) - Age 12-17 - numerator (Column AC)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - numerator
CDF (SMI) - Age 12-17 - denominator (Column AD)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - denominator
CDF (SMI) - Age 18-64 - numerator (Column AE)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - numerator
CDF (SMI) - Age 18-64 - denominator (Column AF)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - denominator
CDF (SMI) - Age 65+ - numerator (Column AG)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - numerator
CDF (SMI) - Age 65+ - denominator (Column AH)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - denominator
6. Health Home Program Reporting Comments	
Column Name	**Explanation**
Comments (Column A)	Enter any relevant information pertaining to the submitted report and the data it contains.

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41

HHP Eligible Condition Diagnosis Codes

Hypertension
I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,
Liver Disease
K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4
TBI
S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

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Bipolar Disorder
F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Major Depressive Disorder
F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39
Psychotic Disorders
F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89
Alcohol Related
F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9
Substance Related
F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D, T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D,

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T40.4X2A, T40.4X2D, T40.4X3A, T40.4X3D, T40.4X4A, T40.4X4D, T40.601A, T40.601D, T40.602A, T40.602D, T40.603A, T40.603D, T40.604A, T40.604D, T40.691A, T40.691D, T40.692A, T40.692D, T40.693A, T40.693D, T40.694A, T40.694D
Kidney Disease
N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0

I. Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

K. Appendix K – Whole Person Care Pilot Interaction Guidance

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Associated with AltaMed Health Services Corporation to include language for the Health Homes Program

Contact

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

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to Amend the CalOptima Medi-Cal Health Network Contracts associated with AltaMed Health Services Corporation to provide Health Homes Program (HHP) services including responsibilities as Community Based-Care Management Entities (CB-CMEs)

Background/Discussion

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option, which is intended to improve member outcomes and reduce health care costs with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. On June 7, 2018, the CalOptima Board of Directors authorized an amendment to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) to incorporate implementation of the HHP. Implementation in Orange County is expected to be effective no sooner than January 1, 2020 for CalOptima Medi-Cal members with eligible chronic physical conditions and substance use disorders (SUD), and no sooner than July 1, 2020 for CalOptima Medi-Cal members with Serious Mental Illness (SMI).

Many of the CB-CME responsibilities are currently being provided by CalOptima's health networks. Consequently, CalOptima will require all health networks, including CalOptima Direct and CalOptima Community Network, to participate in HHP and meet CB-CME requirements. This approach will provide an adequate CB-CME network and ensure continuity of members' relationships with their respective health networks and primary care providers.

In order to implement HHP, staff seeks approval to amend CalOptima's health network contract associated with AltaMed Health Services Corporation to include expectations of CB-CME responsibilities to provide HHP services effective January 1, 2020. Prior to implementing HHP, CalOptima will coordinate with the health networks regarding the development of infrastructure, policies and procedures, reporting capabilities, staffing ratio requirements, and the ability to deliver core services with added intensity and new select services, where appropriate.

Fiscal Impact

The anticipated implementation date for HHP in Orange County is January 1, 2020. Management has included projected revenues and expenses for HHP in the CalOptima Fiscal Year 2019-20 Operating Budget and will for future operating budgets. Total actual revenue and expenses for HHP will depend on the number of members that choose to participate in the program. Based on projected enrollment and

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draft rates received from DHCS on April 2, 2018, CalOptima is projected to receive $26.3 million in funding for HHP over a three-year period.

Since this is a new program for CalOptima, there is the possibility that the rate development assumptions applied by DHCS may be materially different from CalOptima's actual utilization and expenses. Staff will closely monitor both utilization and expenses and will continue to work with DHCS to ensure that Medi-Cal revenue will be sufficient to support the program.

Rationale for Recommendation

The above actions will enable CalOptima to operationally prepare for the anticipated implementation of Health Homes Program, effective January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD and July 1, 2020, for members with SMI.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
2. Department of Health Care Services. Medi-Cal Health Homes Program, Program Guide 7/1/19
3. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements

/s/ Michael Schrader *9/25/2019*

Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

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- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

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	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

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A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II. HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III. HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in <u>at least one</u> of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

Acuity Eligibility Criteria

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above. MCPs must have a process to verify eligibility as part of the enrollment process. MCPs can do this through reviews of the MCPs data and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

MCPs should make a preliminary eligibility determination based on their data prior to proceeding with proactive outreach and engagement. MCPs may rely on the TEL to verify that the member meets the eligibility criteria for having the eligible chronic conditions and the acuity criteria relating to having three or more of the eligible chronic conditions; however, the MCP should verify utilization acuity criteria (within 12 months) using the MCP's own data.

MCPs are required to review their own data for members who are on the TEL and should not proactively outreach members whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions. MCPs may also apply their own additional prioritization policies upon approval from DHCS.

At the point in time when the MCP makes this data-driven preliminary eligibility determination, the member will be considered eligible for the program regardless of how long it takes the member to agree to enroll. The member may be enrolled for at least one month to complete the member assessment and care plan process. If additional information is determined during the assessment/care plan process that negates prior eligibility data or confirms an exclusionary criteria, then the member will be disenrolled.

Homeless Eligibility Criteria

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section 50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her*

residence." For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

People Excluded from Targeted Engagement List

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
    1) Engage the member in the HHP and their own care
    2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
    3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
    4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
    1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
    2) How trauma-informed care best practices will be utilized?
    3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
    1) How the HAP is shared with other providers and if it can be shared electronically; and
    2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
    1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
    2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support

- Working with the member to implement their HAP
- Assisting the member in navigating health, behavioral health, and social services systems, including housing
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Identifying barriers to the member's treatment and medication management adherence
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Assisting in attainment of the member's goals as described in the HAP
- Encouraging the member's decision making and continued participation in HHP
- Accompanying members to appointments as needed

2) Coordination

- Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
- Creating and promoting linkages to other services and supports
- Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
    i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
    ii. Tier 1 – two in-person visits per month
    iii. Tier 2 – 1 in-person visit per month
    iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V. Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.
f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.
g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.
h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.
i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.
b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies
b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers
c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges
d. Track and share data with CB-CMEs regarding each member's health history
e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of

both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To

facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but

are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:

a. Letter to member followed by phone call to member
b. Phone call to member, outreach to care delivery partners and social service partners
c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities.

The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

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- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

SAMPLE

B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or
3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or
3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or
3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

- Nursing Facility Residents
- Hospice Recipients
- Members with TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or AHF
- Members in Cal MediConnect

b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

- Dually eligible members
- Members in CCS or GHPP
- Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Filler	Filler	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Filler	Filler	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

D. Appendix D – Readiness Requirements and Checklist

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI– MHP-MOU: Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

SMI Network: Section III – Network (Deliverables #6.2a and 6.2b)

Group	Counties	Deliverable Due Dates		Deliverable Approval Dates
Group 1	San Francisco	**P&Ps**:	3/1/18	5/1/18
		Network:	5/1/18	6/1/18
		SMI Deliverables:	11/1/18	12/1/18
Group 2	Riverside San Bernardino	**P&Ps**:	9/1/18	11/1/18
		Network:	11/1/18	12/1/18
		SMI MHP-MOU:	2/1/19	3/1/19
		SMI Network:	5/1/19	6/1/19
Group 3.1	Imperial Santa Clara	**P&Ps**:	1/1/19	5/1/19
		Network:	4/1/19	6/1/19
		SMI MHP-MOU:	7/1/19	8/1/19
		SMI Network:	10/1/19	12/1/19
Group 3.2	Alameda Kern Los Angeles Sacramento San Diego Tulare	**P&Ps**:	3/1/19	5/1/19
		Network:	5/1/19	6/1/19
		SMI MHP-MOU:	8/1/19	9/1/19
		SMI Network:	11/1/19	12/1/19
Group 4	Orange	**P&Ps**:	9/1/19	11/1/19
		Network:	11/1/19	12/1/19
		SMI MHP-MOU:	2/1/20	3/1/20
		SMI Network:	5/1/20	6/1/20

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.

For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.

When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.
   - Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.

- Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
- Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

5.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

5.2 Submit the Health Action Plan (HAP) template.

5.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:
- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – SMI**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members

with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

☐ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

☐ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

☐ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

☐ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

☐ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

☐ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

☐ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

☐ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

_____	_____
Managed Care Plan	Signature of Authorized Representative
_____	_____
Date	Name of Authorized Representative
	_____
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	**HCPCS Code**	**Modifier**	**Units of Service (UOS)**
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Telehealth and Group Visits

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

F. Appendix F – Evidence of Coverage Template

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• The three months of data must be combined into one figure to represent the quarter, with the exception of member level Homeless and Housing reports and annual reports.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. Member-level detail Homeless/Housing reports are due semi-annually, with the Q2 and Q4 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2 and Member-level Homeless/Housing – April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4 and Member-level Homeless/Housing – October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx

[MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

All report revisions are subject to DHCS review and approval.

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx. to your designated folder in the "DHCS-MCQMD-Data/MCP" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Homeless and Chronically Homeless: see CA Welfare & Institution Code § 14127(e)

Housing Services:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

1. Health Home Program Enrollment Reporting	
***Note:* Only report one (1) exclusionary reason per member excluded from the Program.**	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number MCP excluded because not eligible - well-managed (Column C)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.
Number MCP excluded because declined to participate (Column D)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP.
Number MCP excluded because of unsuccessful engagement (Column E)	Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment.

Number MCP excluded because duplicative program (Column F)	Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following: 1. Duplicative Programs a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH) b. Targeted Case Management (TCM) – County, not Mental Health TCM 2. Programs excluded by DHCS Policy a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month. b. Hospice 3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy
Number MCP excluded because unsafe behavior or environment (Column G)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)	Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following: a. Fee-For-Service b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF) c. Member is deceased
Number externally referred & enrolled (Column I)	Enter the number of members not part of the plan's targeted engagement process, referred to the MCP, that were enrolled. The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Upon MCP review and evaluation, if the individual is approved for HHP and enrolled, they would be included in this measure. If they are not approved for enrollment in HHP, they would be reported in the following measure.
Number externally referred but excluded (Column J)	Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H.
Average monthly number of dedicated care coordination FTEs (Column K)	Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number.
2. Health Home Program Member Activity Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number initial HAP completed within 90 days (Column C)	Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment.
Number initial HAP completed (Column D)	Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter.

3. Health Home Program Homeless/Housing Member Level Detail	
Note: This tab is to be submitted semi-annually in the Q2 report and Q4 report of every year. The Q2 report (due 8/31) will include data for January through June of the current calendar year. The Q4 Report (due 2/28) will include data for July through December of the previous calendar year.	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and semi-annual reporting period. For example, the second reporting period of 2019 will be entered as 2019 Q3-Q4.
Member CIN (Column C)	Enter the Member's Client Identification Number (CIN) for all members that meet Column G and/or Column I.
Member Last Name (Column D)	Enter the Member's Last Name.
Member First Name (Column E)	Enter the Member's First Name.
Member Date of Birth (DOB) (Column F)	Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY.
Homeless HHP Members and HHP Members at Risk for Homelessness During This Reporting Period (Column G)	Indicate whether the HHP enrolled member met the Federal definition of Homeless or required tenancy sustaining services at any point during the reporting period. Enter "Yes" or "No."
Received Housing Services During This Reporting Period (Column H)	Indicate whether the HHP enrolled member received housing services at any point during the reporting period. Enter "Yes" or "No."
Homeless Health Homes Members In Any Enrollment Period (Column I)	Indicate whether the HHP enrolled member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No."

HHP Members who are no longer Homeless On Last Day of This Reporting Period (Column J)	Indicate the HHP enrolled member no longer meets the Federal definition of Homeless, as of the last day of the reporting period. If the member was disenrolled during the reporting period, report as of their last date of enrollment. Enter "Yes" or "No."
4. Health Home Program Network Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
CB-CME NPI # (Column C)	Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors.
Capacity for each CB-CME (Column D)	Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter.
5. Health Home Program Annual CMS Core Measures Reporting	

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the Technical Specifications and Resource Manual link from CMS. Approve the license agreements and download the Technical Specifications.

https://www.medicaid.gov/license-agreement.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-home-information-resource-center%2Fdownloads%2FFFY-18-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The Technical Specifications require reporting results when the SPA is in effect for six or more months of the measurement period. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

Note: **This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year for the data reported: Year.
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator

CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - numerator (Column M)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator

CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CDF (MED) - Age 12-17 - numerator (Column W)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - numerator
CDF (MED) - Age 12-17 - denominator (Column X)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - denominator
CDF (MED) - Age 18-64 - numerator (Column Y)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - numerator
CDF (MED) - Age 18-64 - denominator (Column Z)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - denominator
CDF (MED) - Age 65+ - numerator (Column AA)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - numerator
CDF (MED) - Age 65+ - denominator (Column AB)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - denominator
CDF (SMI) - Age 12-17 - numerator (Column AC)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - numerator
CDF (SMI) - Age 12-17 - denominator (Column AD)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - denominator
CDF (SMI) - Age 18-64 - numerator (Column AE)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - numerator
CDF (SMI) - Age 18-64 - denominator (Column AF)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - denominator
CDF (SMI) - Age 65+ - numerator (Column AG)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - numerator
CDF (SMI) - Age 65+ - denominator (Column AH)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - denominator
6. Health Home Program Reporting Comments	
Column Name	**Explanation**
Comments (Column A)	Enter any relevant information pertaining to the submitted report and the data it contains.

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41

HHP Eligible Condition Diagnosis Codes

Hypertension
I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,
Liver Disease
K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4
TBI
S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

S06.346S, S06.347A, S06.347D, S06.347S, S06.348A, S06.348D, S06.348S, S06.349A, S06.349D, S06.349S, S06.350A, S06.350D, S06.350S, S06.351A, S06.351D, S06.351S, S06.352A, S06.352D, S06.352S, S06.353A, S06.353D, S06.353S, S06.354A, S06.354D, S06.354S, S06.355A, S06.355D, S06.355S, S06.356A, S06.356D, S06.356S, S06.357A, S06.357D, S06.357S, S06.358A, S06.358D, S06.358S, S06.359A, S06.359D, S06.359S, S06.360A, S06.360D, S06.360S, S06.361A, S06.361D, S06.361S, S06.362A, S06.362D, S06.362S, S06.363A, S06.363D, S06.363S, S06.364A, S06.364D, S06.364S, S06.365A, S06.365D, S06.365S, S06.366A, S06.366D, S06.366S, S06.367A, S06.367D, S06.367S, S06.368A, S06.368D, S06.368S, S06.369A, S06.369D, S06.369S, S06.370A, S06.370D, S06.370S, S06.371A, S06.371D, S06.371S, S06.372A, S06.372D, S06.372S, S06.373A, S06.373D, S06.373S, S06.374A, S06.374D, S06.374S, S06.375A, S06.375D, S06.375S, S06.376A, S06.376D, S06.376S, S06.377A, S06.377D, S06.377S, S06.378A, S06.378D, S06.378S, S06.379A, S06.379D, S06.379S, S06.380A, S06.380D, S06.380S, S06.381A, S06.381D, S06.381S, S06.382A, S06.382D, S06.382S, S06.383A, S06.383D, S06.383S, S06.384A, S06.384D, S06.384S, S06.385A, S06.385D, S06.385S, S06.386A, S06.386D, S06.386S, S06.387A, S06.387D, S06.387S, S06.388A, S06.388D, S06.388S, S06.389A, S06.389D, S06.389S, S06.4X0A, S06.4X0D, S06.4X0S, S06.4X1A, S06.4X1D, S06.4X1S, S06.4X2A, S06.4X2D, S06.4X2S, S06.4X3A, S06.4X3D, S06.4X3S, S06.4X4A, S06.4X4D, S06.4X4S, S06.4X5A, S06.4X5D, S06.4X5S, S06.4X6A, S06.4X6D, S06.4X6S, S06.4X7A, S06.4X7D, S06.4X7S, S06.4X8A, S06.4X8D, S06.4X8S, S06.4X9A, S06.4X9D, S06.4X9S, S06.5X0A, S06.5X0D, S06.5X0S, S06.5X1A, S06.5X1D, S06.5X1S, S06.5X2A, S06.5X2D, S06.5X2S, S06.5X3A, S06.5X3D, S06.5X3S, S06.5X4A, S06.5X4D, S06.5X4S, S06.5X5A, S06.5X5D, S06.5X5S, S06.5X6A, S06.5X6D, S06.5X6S, S06.5X7A, S06.5X7D, S06.5X7S, S06.5X8A, S06.5X8D, S06.5X8S, S06.5X9A, S06.5X9D, S06.5X9S, S06.6X0A, S06.6X0D, S06.6X0S, S06.6X1A, S06.6X1D, S06.6X1S, S06.6X2A, S06.6X2D, S06.6X2S, S06.6X3A, S06.6X3D, S06.6X3S, S06.6X4A, S06.6X4D, S06.6X4S, S06.6X5A, S06.6X5D, S06.6X5S, S06.6X6A, S06.6X6D, S06.6X6S, S06.6X7A, S06.6X7D, S06.6X7S, S06.6X8A, S06.6X8D, S06.6X8S, S06.6X9A, S06.6X9D, S06.6X9S, S06.810A, S06.810D, S06.810S, S06.811A, S06.811D, S06.811S, S06.812A, S06.812D, S06.812S, S06.813A, S06.813D, S06.813S, S06.814A, S06.814D, S06.814S, S06.815A, S06.815D, S06.815S, S06.816A, S06.816D, S06.816S, S06.817A, S06.817D, S06.817S, S06.818A, S06.818D, S06.818S, S06.819A, S06.819D, S06.819S, S06.820A, S06.820D, S06.820S, S06.821A, S06.821D, S06.821S, S06.822A, S06.822D, S06.822S, S06.823A, S06.823D, S06.823S, S06.824A, S06.824D, S06.824S, S06.825A, S06.825D, S06.825S, S06.826A, S06.826D, S06.826S, S06.827A, S06.827D, S06.827S, S06.828A, S06.828D, S06.828S, S06.829A, S06.829D, S06.829S, S06.890A, S06.890D, S06.890S, S06.891A, S06.891D, S06.891S, S06.892A, S06.892D, S06.892S, S06.893A, S06.893D, S06.893S, S06.894A, S06.894D, S06.894S, S06.895A, S06.895D, S06.895S, S06.896A, S06.896D, S06.896S, S06.897A, S06.897D, S06.897S, S06.898A, S06.898D, S06.898S, S06.899A, S06.899D, S06.899S, S06.9X0A, S06.9X0D, S06.9X0S, S06.9X1A, S06.9X1D, S06.9X1S, S06.9X2A, S06.9X2D, S06.9X2S, S06.9X3A, S06.9X3D, S06.9X3S, S06.9X4A, S06.9X4D, S06.9X4S, S06.9X5A, S06.9X5D, S06.9X5S, S06.9X6A, S06.9X6D, S06.9X6S, S06.9X7A, S06.9X7D, S06.9X7S, S06.9X8A, S06.9X8D, S06.9X8S, S06.9X9A, S06.9X9D, S06.9X9S, S14.0XXS, S14.101S, S14.102S, S14.103S, S14.104S, S14.105S, S14.106S, S14.107S, S14.108S, S14.109S, S14.111S, S14.112S, S14.113S, S14.114S,

S14.115S, S14.116S, S14.117S, S14.118S, S14.119S, S14.121S, S14.122S, S14.123S, S14.124S, S14.125S, S14.126S, S14.127S, S14.128S, S14.129S, S14.131S, S14.132S, S14.133S, S14.134S, S14.135S, S14.136S, S14.137S, S14.138S, S14.139S, S14.141S, S14.142S, S14.143S, S14.144S, S14.145S, S14.147S, S14.148S, S14.149S, S14.151S, S14.152S, S14.153S, S14.154S, S14.155S, S14.156S, S14.157S, S14.158S, S14.159S, S14.2XXS, S14.3XXS, S14.4XXS, S14.5XXS, S14.8XXS, S14.9XXS, S24.0XXS, S24.101S, S24.102S, S24.103S, S24.104S, S24.109S, S24.111S, S24.112S, S24.113S, S24.114S, S24.119S, S24.131S, S24.132S, S24.133S, S24.134S, S24.139S, S24.141S, S24.142S, S24.144S, S24.149S, S24.151S, S24.152S, S24.153S, S24.154S, S24.159S, S24.2XXS, S24.3XXS, S24.4XXS, S24.8XXS, S24.9XXS, S34.01XS, S34.02XS, S34.101S, S34.102S, S34.103S, S34.104S, S34.105S, S34.109S, S34.111S, S34.112S, S34.113S, S34.114S, S34.115S, S34.119S, S34.121S, S34.122S, S34.123S, S34.124S, S34.125S, S34.129S, S34.131S, S34.132S, S34.139S, S34.21XS, S34.22XS, S34.3XXS, S34.4XXS, S34.5XXS, S34.6XXS, S34.8XXS, S34.9XXS, S44.00XS, S44.01XS, S44.02XS, S44.10XS, S44.12XS, S44.20XS, S44.21XS, S44.22XS, S44.30XS, S44.31XS, S44.32XS, S44.40XS, S44.41XS, S44.42XS, S44.50XS, S44.51XS, S44.52XS, S44.8X1S, S44.8X2S, S44.8X9S, S44.90XS, S44.91XS, S44.92XS, S54.00XS, S54.01XS, S54.02XS, S54.10XS, S54.11XS, S54.12XS, S54.20XS, S54.21XS, S54.22XS, S54.30XS, S54.31XS, S54.32XS, S54.8X1S, S54.8X2S, S54.8X9S, S54.90XS, S54.91XS, S54.92XS, S64.00XS, S64.01XS, S64.02XS, S64.21XS, S64.22XS, S64.30XS, S64.31XS, S64.32XS, S64.40XS, S64.490S, S64.491S, S64.492S, S64.493S, S64.494S, S64.495S, S64.496S, S64.497S, S64.498S, S64.8X1S, S64.8X2S, S64.8X9S, S64.90XS, S64.91XS, S64.92XS, S74.00XS, S74.01XS, S74.02XS, S74.10XS, S74.11XS, S74.12XS, S74.20XS, S74.21XS, S74.22XS, S74.8X1S, S74.8X2, S74.8X9S, S74.90XS, S74.91XS, S74.92XS, S84.00XS, S84.01XS, S84.02XS, S84.10XS, S84.11XS, S84.12XS, S84.20XS, S84.21XS, S84.22XS, S84.801S, S84.802S, S84.809S, S84.90XS, S84.91XS, S84.92XS, S94.00XS, S94.01XS, S94.02XS, S94.10XS, S94.11XS, S94.12XS, S94.20XS, S94.21XS, S94.22XS, S94.30XS, S94.31XS, S94.32XS, S94.8X1S, S94.8X2S, S94.8X9S, S94.90XS, S94.91XS, S94.92XS
Bipolar Disorder
F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Major Depressive Disorder
F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39
Psychotic Disorders
F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89
Alcohol Related
F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9
Substance Related
F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D, T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D,

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T40.4X2A, T40.4X2D, T40.4X3A, T40.4X3D, T40.4X4A, T40.4X4D, T40.601A, T40.601D, T40.602A, T40.602D, T40.603A, T40.603D, T40.604A, T40.604D, T40.691A, T40.691D, T40.692A, T40.692D, T40.693A, T40.693D, T40.694A, T40.694D
Kidney Disease
N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0

I. Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

K. Appendix K – Whole Person Care Pilot Interaction Guidance

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Authorizing Contract with Vendor for Health Homes Program Select Services for Accompaniment and Housing Related Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve recommended vendor Illumination Foundation for HHP select services for accompaniment and housing related services;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with the recommended vendor, effective January 1, 2020; and
3. In the event CalOptima and Illumination Foundation are unable to reach agreeable contract terms within thirty (30) days, authorize the CEO, with the assistance of Legal Counsel, to enter into an agreement with the next qualified bidder, Maxim Healthcare Services, for HHP select services for accompaniment and housing related services.

Background

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option. The intent of HHP is to improve member outcomes and reduce health care costs. In California, Assembly Bill 361 (2013) authorizes implementation of the Health Home Program. HHP, which is an entitlement benefit, is being implemented in selected counties in a phased in implementation approach, with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. On June 7, 2018, the CalOptima Board of Directors (Board) authorized an amendment to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) to incorporate implementation of the HHP. Implementation in Orange County is expected to be effective no sooner than January 1, 2020 for CalOptima Medi-Cal members with eligible chronic physical conditions and substance use disorders (SUD), and no sooner than July 1, 2020 for CalOptima Medi-Cal members with Serious Mental Illness (SMI).

To support development of HHP, Section 2703 of the ACA provides enhanced funding to states. Rather than the standard Medicaid funding (Federal 50%/State 50%), the Center for Medicare & Medicaid Services (CMS) will fund 90% for the first two years following implementation, effective for each phase. California Assembly Bill 361 requires budget neutrality and that no state general funds are used towards the program. As such, the California Endowment is funding the remaining 10% of funds for HHP. After the first two years, the funding returns to the standard Medicaid funding (Federal 50%/State 50%).

Pursuant to the DHCS Program Guide and All Plan Letter 18-012: Health Homes Program Requirements, MCPs will be responsible for overall administration, including development of HHP network. DHCS also published an HHP Program Guide that outlines the responsibilities of the MCPs

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and Community-Based Care Management Entities (CB-CMEs). Per the DHCS requirements, HHP services are to be provided and coordinated through the network of CB-CMEs. In addition, CB-CMEs are responsible for coordinating care with members, providers and other agencies as appropriate. HHP Program Guide requires the following six core service categories for members enrolled in HHP:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Under HHP, members will be eligible for new services, including housing navigation, housing tenancy sustainability, and accompaniment to clinical appointments. CalOptima plans to contract with a vendor for these HHP select services.

Discussion

New HHP services include accompaniment to clinical appointments, housing transition services and tenancy sustaining services. Following CalOptima's standard RFP process in accordance with CalOptima Policy GA.5002: Purchasing, CalOptima staff conducted a Request For Proposal (RFP) processes to procure vendors for these new HHP select services beginning January 1, 2020. The new HHP select services are provided in-person and do not include direct medical care services. An HHP select services vendor is not required to be registered with the Medi-Cal program. Health networks, as CB-CMEs, will have the ability to contract with the selected vendor(s).

In response to the RFP, CalOptima received responses from:

- American Family Housing
- Illumination Foundation
- Maxim Healthcare Services

The submitted proposals were reviewed by an internal evaluation team consisting of representatives from Business Integration, Medical Affairs, Strategic Development, Network Management, Contracting, Vendor Management, Operations, Finance, Behavioral Health and Information Services.

The recommended vendor will provide the HHP select services in-person and participate in the member's care team meetings. The vendor is expected to capture, track, and report all services and coordinated efforts to CalOptima and care team members as appropriate. Additionally, the vendor will make the same HHP select services available to the health networks either through CalOptima's contract or a separate contract with the individual health network.

Vendor	Final Weighted Score
American Family Housing	11.00
Illumination Foundation	22.35
Maxim Healthcare Services	16.60

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Based on the final weighed scores, staff recommends contracting with the Illumination Foundation for select HHP services.

Founded in 2008, Illumination Foundation is a 501 (c)(3) non-profit organization dedicated to the mission of providing targeted and interdisciplinary services. Illumination Foundation has experience working with similar populations as HHP eligible members. They believe that every person has an intrinsic right to home, health, and dignity. Their direct client care staff includes case managers, housing navigators, behavioral health therapists, substance use counselors, and a variety of healthcare workers (LVNS, RNs, nurse practitioners) who follow clients as they access emergency shelter, recuperative care, and housing related services with the overall goal to achieve longer-term health and housing outcomes. The agency has served more than 52,825 individuals since its inception.

Fiscal Impact

The anticipated implementation date for HHP in Orange County is January 1, 2020. Management has included projected revenues and expenses for HHP in the CalOptima Fiscal Year 2019-20 Operating Budget and will for future operating budgets. Total actual revenue and expenses for HHP will depend on the number of members that choose to participate in the program. Based on projected enrollment and draft rates received from DHCS on April 2, 2018, CalOptima is projected to receive $26.3 million in funding for HHP over a three-year period.

Since this is a new program for CalOptima, there is the possibility that the rate development assumptions applied by DHCS may be materially different from CalOptima's actual utilization and expenses. Staff will closely monitor both utilization and expenses and will continue to work with DHCS to ensure that Medi-Cal revenue will be sufficient to support the program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated implementation of Health Homes Program, effective January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD, and July 1, 2020, for members with SMI.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
3. Department of Health Care Services Medi-Cal Health Homes Program, Program Guide 7/1/19
4. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements
5. HHP Select Services RFP

/s/ Michael Schrader *9/25/2019*

Authorized Signature **Date**

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Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 16

Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip
American Family Housing	15161 Jackson Street	Midway City	CA	92655
Illumination Foundation	1091 N. Batavia St.	Orange	CA	92867
Maxim Healthcare Services	7227 Lee Deforest Drive	Columbia	MD	21046

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

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- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

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	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

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A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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Program Guide
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I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II. HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III. HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in <u>at least one</u> of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

Acuity Eligibility Criteria

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above. MCPs must have a process to verify eligibility as part of the enrollment process. MCPs can do this through reviews of the MCPs data and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

MCPs should make a preliminary eligibility determination based on their data prior to proceeding with proactive outreach and engagement. MCPs may rely on the TEL to verify that the member meets the eligibility criteria for having the eligible chronic conditions and the acuity criteria relating to having three or more of the eligible chronic conditions; however, the MCP should verify utilization acuity criteria (within 12 months) using the MCP's own data.

MCPs are required to review their own data for members who are on the TEL and should not proactively outreach members whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions. MCPs may also apply their own additional prioritization policies upon approval from DHCS.

At the point in time when the MCP makes this data-driven preliminary eligibility determination, the member will be considered eligible for the program regardless of how long it takes the member to agree to enroll. The member may be enrolled for at least one month to complete the member assessment and care plan process. If additional information is determined during the assessment/care plan process that negates prior eligibility data or confirms an exclusionary criteria, then the member will be disenrolled.

Homeless Eligibility Criteria

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section 50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her*

residence." For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

People Excluded from Targeted Engagement List

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
    1) Engage the member in the HHP and their own care
    2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
    3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
    4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
    1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
    2) How trauma-informed care best practices will be utilized?
    3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
    1) How the HAP is shared with other providers and if it can be shared electronically; and
    2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
    1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
    2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support

- Working with the member to implement their HAP
- Assisting the member in navigating health, behavioral health, and social services systems, including housing
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Identifying barriers to the member's treatment and medication management adherence
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Assisting in attainment of the member's goals as described in the HAP
- Encouraging the member's decision making and continued participation in HHP
- Accompanying members to appointments as needed

2) Coordination

- Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
- Creating and promoting linkages to other services and supports
- Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
    i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
    ii. Tier 1 – two in-person visits per month
    iii. Tier 2 – 1 in-person visit per month
    iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V. Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.
f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.
g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.
h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.
i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.
b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies
b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers
c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges
d. Track and share data with CB-CMEs regarding each member's health history
e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of

both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To

facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but

are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:

a. Letter to member followed by phone call to member
b. Phone call to member, outreach to care delivery partners and social service partners
c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities.

The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

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- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

SAMPLE

B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or
3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or
3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or
3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

- Nursing Facility Residents
- Hospice Recipients
- Members with TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or AHF
- Members in Cal MediConnect

b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

- Dually eligible members
- Members in CCS or GHPP
- Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Filler	Filler	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Filler	Filler	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

D. Appendix D – Readiness Requirements and Checklist

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI– MHP-MOU: Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

SMI Network: Section III – Network (Deliverables #6.2a and 6.2b)

Group	Counties	Deliverable Due Dates		Deliverable Approval Dates
Group 1	San Francisco	**P&Ps**:	3/1/18	5/1/18
		Network:	5/1/18	6/1/18
		SMI Deliverables:	11/1/18	12/1/18
Group 2	Riverside San Bernardino	**P&Ps**:	9/1/18	11/1/18
		Network:	11/1/18	12/1/18
		SMI MHP-MOU:	2/1/19	3/1/19
		SMI Network:	5/1/19	6/1/19
Group 3.1	Imperial Santa Clara	**P&Ps**:	1/1/19	5/1/19
		Network:	4/1/19	6/1/19
		SMI MHP-MOU:	7/1/19	8/1/19
		SMI Network:	10/1/19	12/1/19
Group 3.2	Alameda Kern Los Angeles Sacramento San Diego Tulare	**P&Ps**:	3/1/19	5/1/19
		Network:	5/1/19	6/1/19
		SMI MHP-MOU:	8/1/19	9/1/19
		SMI Network:	11/1/19	12/1/19
Group 4	Orange	**P&Ps**:	9/1/19	11/1/19
		Network:	11/1/19	12/1/19
		SMI MHP-MOU:	2/1/20	3/1/20
		SMI Network:	5/1/20	6/1/20

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.

For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.

When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.
   - Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.

- Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
- Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

5.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

5.2 Submit the Health Action Plan (HAP) template.

5.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:
- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – SMI**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members

with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

☐ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

☐ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

☐ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

☐ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

☐ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

☐ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

☐ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

☐ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

_____	_____
Managed Care Plan	Signature of Authorized Representative
_____	_____
Date	Name of Authorized Representative
	_____
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	**HCPCS Code**	**Modifier**	**Units of Service (UOS)**
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Telehealth and Group Visits

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

F. Appendix F – Evidence of Coverage Template

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• The three months of data must be combined into one figure to represent the quarter, with the exception of member level Homeless and Housing reports and annual reports.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. Member-level detail Homeless/Housing reports are due semi-annually, with the Q2 and Q4 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2 and Member-level Homeless/Housing – April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4 and Member-level Homeless/Housing – October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx

[MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

All report revisions are subject to DHCS review and approval.

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx. to your designated folder in the "DHCS-MCQMD-Data/MCP" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Homeless and Chronically Homeless: see CA Welfare & Institution Code § 14127(e)

Housing Services:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

1. Health Home Program Enrollment Reporting	
***Note:* Only report one (1) exclusionary reason per member excluded from the Program.**	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number MCP excluded because not eligible - well-managed (Column C)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.
Number MCP excluded because declined to participate (Column D)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP.
Number MCP excluded because of unsuccessful engagement (Column E)	Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment.

Number MCP excluded because duplicative program (Column F)	Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following: 1. Duplicative Programs a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH) b. Targeted Case Management (TCM) – County, not Mental Health TCM 2. Programs excluded by DHCS Policy a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month. b. Hospice 3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy
Number MCP excluded because unsafe behavior or environment (Column G)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)	Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following: a. Fee-For-Service b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF) c. Member is deceased
Number externally referred & enrolled (Column I)	Enter the number of members not part of the plan's targeted engagement process, referred to the MCP, that were enrolled. The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Upon MCP review and evaluation, if the individual is approved for HHP and enrolled, they would be included in this measure. If they are not approved for enrollment in HHP, they would be reported in the following measure.
Number externally referred but excluded (Column J)	Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H.
Average monthly number of dedicated care coordination FTEs (Column K)	Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number.
2. Health Home Program Member Activity Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number initial HAP completed within 90 days (Column C)	Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment.
Number initial HAP completed (Column D)	Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter.

3. Health Home Program Homeless/Housing Member Level Detail	
Note: This tab is to be submitted semi-annually in the Q2 report and Q4 report of every year. The Q2 report (due 8/31) will include data for January through June of the current calendar year. The Q4 Report (due 2/28) will include data for July through December of the previous calendar year.	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and semi-annual reporting period. For example, the second reporting period of 2019 will be entered as 2019 Q3-Q4.
Member CIN (Column C)	Enter the Member's Client Identification Number (CIN) for all members that meet Column G and/or Column I.
Member Last Name (Column D)	Enter the Member's Last Name.
Member First Name (Column E)	Enter the Member's First Name.
Member Date of Birth (DOB) (Column F)	Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY.
Homeless HHP Members and HHP Members at Risk for Homelessness During This Reporting Period (Column G)	Indicate whether the HHP enrolled member met the Federal definition of Homeless or required tenancy sustaining services at any point during the reporting period. Enter "Yes" or "No."
Received Housing Services During This Reporting Period (Column H)	Indicate whether the HHP enrolled member received housing services at any point during the reporting period. Enter "Yes" or "No."
Homeless Health Homes Members In Any Enrollment Period (Column I)	Indicate whether the HHP enrolled member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No."

HHP Members who are no longer Homeless On Last Day of This Reporting Period (Column J)	Indicate the HHP enrolled member no longer meets the Federal definition of Homeless, as of the last day of the reporting period. If the member was disenrolled during the reporting period, report as of their last date of enrollment. Enter "Yes" or "No."
4. Health Home Program Network Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
CB-CME NPI # (Column C)	Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors.
Capacity for each CB-CME (Column D)	Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter.
5. Health Home Program Annual CMS Core Measures Reporting	

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the Technical Specifications and Resource Manual link from CMS. Approve the license agreements and download the Technical Specifications.

https://www.medicaid.gov/license-agreement.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-home-information-resource-center%2Fdownloads%2FFFY-18-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The Technical Specifications require reporting results when the SPA is in effect for six or more months of the measurement period. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

Note: **This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year for the data reported: Year.
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator

CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - numerator (Column M)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator

CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CDF (MED) - Age 12-17 - numerator (Column W)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - numerator
CDF (MED) - Age 12-17 - denominator (Column X)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - denominator
CDF (MED) - Age 18-64 - numerator (Column Y)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - numerator
CDF (MED) - Age 18-64 - denominator (Column Z)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - denominator
CDF (MED) - Age 65+ - numerator (Column AA)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - numerator
CDF (MED) - Age 65+ - denominator (Column AB)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - denominator
CDF (SMI) - Age 12-17 - numerator (Column AC)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - numerator
CDF (SMI) - Age 12-17 - denominator (Column AD)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - denominator
CDF (SMI) - Age 18-64 - numerator (Column AE)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - numerator
CDF (SMI) - Age 18-64 - denominator (Column AF)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - denominator
CDF (SMI) - Age 65+ - numerator (Column AG)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - numerator
CDF (SMI) - Age 65+ - denominator (Column AH)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - denominator
6. Health Home Program Reporting Comments	
Column Name	**Explanation**
Comments (Column A)	Enter any relevant information pertaining to the submitted report and the data it contains.

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41

HHP Eligible Condition Diagnosis Codes

Hypertension
I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,
Liver Disease
K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4
TBI
S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

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Bipolar Disorder
F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Major Depressive Disorder
F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39
Psychotic Disorders
F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89
Alcohol Related
F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9
Substance Related
F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D, T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D,

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N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0

I. Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

K. Appendix K – Whole Person Care Pilot Interaction Guidance

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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June 06, 2019

NOTICE OF REQUEST FOR PROPOSALS (RFP)

#19-021A

GENERAL CONDITIONS AND INSTRUCTIONS TO OFFERORS

For

Health Homes Program Select Services – Revised

Key RFP Dates

Written Questions Due: June 24, 2019, 2:00, PM Pacific Time
Proposal Submittal Date: July 11, 2019, 2:00 PM Pacific Time

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Inviting Request for Proposals (RFP) 19-021A for Health Homes Program Select Services - Revised

CalOptima invites Proposals from qualified Offerors to provide Health Homes Program Select Services - Revised. Proposals shall be prepared and submitted in accordance with the requirements set forth in this RFP #19-021A. **Proposals must be submitted via BidSync no later than 2:00 PM Pacific Time, July 11, 2019.**

Proposals, and amendments to Proposals received after the date and time specified above will be rejected by the BidSync program and will not be delivered to CalOptima.

CalOptima's Basic Philosophy: Contracting for Results

CalOptima's fundamental commitment is to contract for results. CalOptima defines a successful result as a generation of defined, measurable, and beneficial outcomes that satisfy the contract requirements and support CalOptima's mission and objectives. This RFP 19-021A describes what is required of the successful Offeror in terms of services, deliverables, performance measures and outcomes, and unless otherwise noted in this RFP, places the responsibility for how they are accomplished on the successful Offeror.

Contract Elements

The term "contract" means the contract awarded as a result of this RFP 19-021A and all exhibits thereto. (See RFP Attachment 4: CalOptima Sample Contract). The successful Offeror/s will be required to accept a written contract in accordance with and included as a part thereof, this Request for Proposal, including all requirements, conditions and specifications contained therein. The Proposal, including all attachments and information on services, and associated pricing shall be binding and shall be incorporated into the written contract. At a minimum, the following documents will be incorporated into the contract:

- This RFP 19-021A and all attachments and exhibits.
- Any modifications, addendum or amendments issued in conjunction with this RFP 19-021A.
- The successful Offeror's Proposal.

Should there be any conflict between RFP 19-021A and the contract, the terms and conditions of the contract shall prevail.

It should be noted that as a public agency, CalOptima is mandated by various government entities to incorporate many of the terms and conditions listed within the entities Contract and BAA, and is unable to modify them in any way.

CalOptima is permitting each Offeror to identify the terms of the Contract and BAA it would like to negotiate. Using Attachment 5 entitled "Request to Negotiate Contract/BAA Terms," Offerors must identify the Current Language, Proposed Language, and Rationale for the

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Request. Note that any request to negotiate contract terms without a rationale will not be considered for negotiation. CalOptima will evaluate all requests and render a decision on each Contract/BAA term identified.

If a "Request to Negotiate Contract/BAA Terms" form is not submitted with the proposal, the terms submitted in the Sample Contract will be in force. CalOptima will not review any changes marked on the Contract/BAA PDFs that are not included on the "Request to Negotiate Contract/BAA Terms" form. CalOptima will also not review any additional terms & conditions submitted by Vendor on Vendor paper. Even if you currently have an existing contract/BAA with CalOptima or have had one in the past, the services within this RFP are considered separate and CalOptima **will not** add them to an existing agreement.

Each deletion, addition, and modification, etc., to CalOptima's Sample Contract or BAA must be logged and submitted on the "Request to Negotiate Contract Terms" form. Failure to do so will result in your proposal being deemed non-responsive. Even if you currently have a contract or BAA with CalOptima or have had one in the past, a "Request to Negotiate Contract Terms" form must be created and included as part of your firms' proposal.

CalOptima may disqualify and terminate negotiations with any Offeror that did not take exception to a given Sample Contract or BAA provision in its proposal and subsequently attempts to do so during negotiations. As such, it is in Offeror's best interest to have the Sample Contract reviewed by counsel prior to submitting a proposal.

The successful Offeror will be required to comply with all applicable equal opportunity laws and regulations.

Sincerely,

Ryan Prest
Purchasing Manager

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SECTION I: CALOPTIMA BACKGROUND AND OVERVIEW

A. County Organized Health Systems (COHS) Background

The California State Medicaid (Medi-Cal) program came into existence in March 1966 as a fee-for-service health care delivery system. In May 1972, Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary and limited to those in a public assistance aid category.

In June 1983, a new type of managed care program, the County Organized Health System (COHS), became operational. The COHS managed care model ensures Med-Cal recipients access to comprehensive, cost-effective health care. Each COHS plan is sanctioned by the County Board of Supervisors and governed by an independent commission.

B. CalOptima Overview

CalOptima's Overview can be located by clicking on the following link and by selecting 'View CalOptima Fast Facts": https://www.caloptima.org/AboutUs.aspx

SECTION II: INSTRUCTIONS AND CONDITIONS

A. General Requirements

1.0 This RFP 19-021A contains a list of requirements for the successful Offeror. A qualified Offeror, for the purpose of this RFP 19-021A, is an Offeror that can reliably, competently and independently provide the required services to CalOptima for the entire term of the agreement. The contract term is One (1) year with Three (3), one year renewal options at CalOptima's discretion.

2.0 As required under Ordinance No. 3896 of the County of Orange, State of California, Offeror hereby acknowledges and agrees that the obligations of CalOptima under any resulting contract are solely the obligation of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

B. Instructions and Conditions

1.0 Examination of Proposal Documents

1.1 Before submitting a Proposal, each Offeror represents that it has thoroughly examined and become familiar with the work required under this RFP 19-021A and it is capable of performing quality work to achieve CalOptima's objectives.

1.2 Each Offeror must be satisfied by personal examination, and by such other means as it may prefer, as to the actual conditions and requirements under which the contract will be performed.

1.3 CalOptima reserves the right to remove from its list for future RFPs, for an undetermined period of time, the name of any Offeror for failure to accept a contract, failure to respond to two consecutive RFPs and/or unsatisfactory performance. Please note that a "No Bid" is considered a response.

2.0 Addenda

CalOptima may make changes to the requirements of this RFP 19-021A. Any CalOptima changes to the requirements will be made by written addendum to this RFP 19-021A. Any written addenda issued pertaining to this RFP 19-021A shall be incorporated into the terms and conditions of any resulting contract. CalOptima will not be bound to any modifications to, or deviations from, the requirements set forth in this RFP 19-021A as the result of oral instruction. All addenda will be submitted by CalOptima via BidSync.

3.0 Procurement Schedule

The following table presents the anticipated schedule for this procurement. All dates are subject to change at CalOptima's discretion. Changes to the schedule will be communicated via an addendum to this RFP through BidSync.

Event	Date
RFP 19-021A Issue Date	June 06, 2019
Written Questions due from Offerors via BidSync	June 24, 2019
Responses to Questions due from CalOptima via BidSync	June 27, 2019
Proposals due from Offerors via BidSync	July 11, 2019
Demonstrations/Interviews/Site Visits/Reference Checks	August 05 - 08, 2019
Vendor Selection	August 14, 2019

4.0 Procurement Point-of-Contact

4.1 All communications relating to this RFP 19-021A must be directed to CalOptima's designated contact below:

Ryan Prest
rprest@caloptima.org
CalOptima Vendor Management Department
505 City Parkway West
Orange, CA 92868

4.2 Any and all communications relating to this RFP must be directed to the Vendor Management Point-of-Contact named above. Communications relating to this RFP between respondents and other CalOptima staff members concerning this RFP are strictly prohibited. Failure to comply with these requirements will result in Proposal disqualification.

5.0 Questions and Clarifications

5.1 If an Offeror desires an explanation or clarification of any kind regarding a provision of this RFP 19-021A, the Offeror must generate a written request for such explanation or clarification through BidSync by 2:00, PM Pacific Time, June 24, 2019. Inquiries received after 2:00 PM Pacific Time, June 24, 2019 will not be responded to.

5.2 CalOptima responses will be communicated via BidSync, and will be sent no later than 5:00 PM Pacific Time, June 27, 2019.

6.0 Proposal Preparation

6.1 Proposals shall be typed in 12 point font and submitted via BidSync in a Word, Excel or PDF format. Do not provide zip files. Offerors should not include any unnecessarily elaborate or promotional material.

6.2 Information shall be presented and submitted through BidSync and must be submitted in the order in which it is requested. Please limit your responses to no more than five (5) documents. Each file name must contain your company name and RFP number. The responses must directly address the items requested in each requirement. Complete, concise and specific responses are required. Lengthy narrative is discouraged.

6.3 Letter of Transmittal

A mandatory Letter of Transmittal shall be included with the Proposal and must, at a minimum, contain the following:

- Identification of Offeror, including name, address and telephone number.
- Name, title, e-mail address and telephone number of Offeror's representative during the period of proposal evaluation.
- Proposed working relationship between Offeror and subcontractors, and if not applicable, indicate so.
- A statement to the effect that the Proposal shall remain valid for a period of not less than 150 calendar days from the Proposal due date.
- Signature of a person authorized to bind Offeror to the terms of the Proposal.
- Either a statement indicating no contract changes or submit a Request to Negotiate Contract Terms as presented in this RFP as Attachment 5).
- A statement clarifying if you are bidding on one or both or the available select services.

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7.0 Proposal Submittal

7.1 Date and Time

All Proposals must be submitted via BidSync and must be submitted no later than 2:00 PM Pacific Time, July 11, 2019. CalOptima recommends you begin the submission process well in advance of the proposal submission deadline to allow ample time for transmission.

7.2 Acceptance of Proposals

7.2.1 CalOptima reserves the right to accept or reject any and all proposals, or any item or part thereof, or to waive any informalities or irregularities in proposals.

7.2.2 CalOptima reserves the right to withdraw this RFP at any time without prior notice and CalOptima makes no representations that a contract will be awarded to any Offeror responding to this RFP.

7.2.3 CalOptima reserves the right to postpone proposal opening for its own convenience.

8.0 Pre-Contractual Expenses

8.1 Pre-contractual expenses are defined as expenses incurred by the Offeror in:

- preparing its proposal in response to this RFP;
- submitting its proposal to CalOptima;
- negotiating with CalOptima on any matter related to its proposal; or
- any other expenses incurred by the Offeror prior to date of award, if any, of the contract.

8.2 CalOptima shall not, in any event, be liable for any pre-contractual expenses incurred by Offeror in the preparation of its proposal. Offeror shall not include any such expenses as part of its proposal.

9.0 Joint Offers

Where two or more Offerors desire to submit a single proposal in response to this RFP 19-021A, they should do so on a prime-subcontractor basis rather than as a joint venture. CalOptima intends to contract with a single firm and not with multiple firms doing business as a joint venture.

10.0 Non-Collusion Affidavit

As part of its Proposal, Offerors are required to complete and sign the Non-Collusion Affidavit provided as RFP Attachment 2. Proposals submitted to CalOptima without a fully executed copy of the Non-Collusion Affidavit will be considered non-responsive.

11.0 Contract Type and Term

11.1 It is anticipated that the contract resulting from this solicitation, if awarded, will be a firm-fixed price contract unless otherwise specified.

11.2 The initial term of any resulting agreement shall be for a period of One (1) year, with an anticipated effective date of TBD, with Three (3) consecutive, one year renewal options at CalOptima's discretion.

12.0 Eligibility for Contract Award

CalOptima will not award this RFP or enter into a contract with any Offeror who is debarred, suspended or otherwise ineligible for the award of a contract or grant by any Federal agency or from participating in Federal Healthcare Programs. By submission of this proposal, Offeror

acknowledges and warrants that the Offeror and any of its officers, directors, owners, partners, or any person having primary management or supervisory responsibilities within the Offeror's business are not presently debarred, suspended, proposed for debarment or declared ineligible for the award of contracts by any Federal agency or from participating in any Federal healthcare programs. Offerors must complete RFP Attachment 3 entitled "Offeror Eligibility Certification" and submit as part of its proposal.

13.0 Withdrawal of Offers

Offers may be withdrawn only by signature of Offeror, provided the request is received by the person whose duty it is to open proposals prior to the time fixed for proposal opening. Each proposal opened will be considered to be a valid offer.

14.0 Use of Offeror Response and Accompanying Material

14.1 All materials submitted become the property of CalOptima and will not be returned. If the Offeror intends to submit confidential or proprietary information as part of the proposal, any limits on the use or distribution of that material should be clearly delineated in writing. However, CalOptima is a public agency and therefore subject to the California Public Records Act (California Government Code, Section 6250 et seq).

14.2 CalOptima will use reasonable precautions allowed by law to avoid disclosure of the Offeror proposal. CalOptima reserves the unrestricted right to copy and disseminate the Offeror proposals for internal review and for review by external advisors, at CalOptima's sole discretion.

15.0 Evaluation and Award of Contract

15.1 Issuance of this RFP 19-021A or receipt of proposals does not commit CalOptima to award a contract. CalOptima reserves the right to withdraw this RFP 19-021A at any time without further notice and, furthermore, makes no representation that any contract will be awarded to any Offeror responding to this RFP 19-021A. CalOptima expressly reserves the right to postpone proposal opening for its own convenience; to accept or reject any or all proposals received in response to this RFP 19-021A; to waive informalities and minor irregularities in bids received; to reject any and all proposals responding to this RFP 19-021A without indicating any reasons for such rejection; to negotiate with other than the selected Offeror should negotiations with the selected Offeror be terminated; to negotiate with more than one Offeror simultaneously or to cancel all or part of this RFP 19-021A.

15.2 In no event will CalOptima be limited to selecting a successful Offeror based solely upon total cost submitted. Evaluation of the Proposals shall be generally based upon the reasonableness of price; experience in the market; capabilities of the Offeror to effectively complete the project requirements; financial stability and completeness of the Proposal response and the requested data. All proposals received as specified will be evaluated by CalOptima staff in accordance with the above criteria and additional sub-criteria that may be considered as relevant or pertinent by the evaluators.

15.3 In accordance with CalOptima's purchasing policy, CalOptima staff may select one or more responsive, responsible Offeror(s) whose Proposal(s) are most advantageous to CalOptima– price, quality and other factors considered.

15.4 False, incomplete, or unresponsive statements in connection with a Proposal may be cause for rejection. The evaluation and determination of fulfillment for the above requirements shall be in CalOptima's sole judgment and this judgment shall be final. Any Proposal not meeting terms and conditions may be rejected.

15.5 Offerors who submit a proposal in response to this RFP 19-021A shall be notified in writing regarding whether its firm was awarded the contract or not. Such notification shall be made within a reasonable time after the date the contract is executed.

16.0 Exceptions/Deviations

16.1 CalOptima requires each Offeror to state any exceptions to or deviations from the requirements of this RFP 19-021A, separating "technical" exceptions from "contractual" exceptions. Where Offeror wishes to propose alternative approaches to meeting CalOptima's technical requirements, these should be thoroughly explained.

16.2 Each deletion, addition, and modification, etc. to CalOptima's contract or BAA must be logged and submitted in the "Request to Negotiate Contract/BAA Terms" form (Attachment 5 of this RFP). Failure to do so will result in your firm's proposal being deemed non-responsive. Even if you currently have a contract or BAA with CalOptima or have had one in the past, the services within this RFP are considered separate and CalOptima will not add them to an existing agreement.

17.0 Appendices

Information considered by Offeror to be pertinent to this project and which has not been specifically solicited in any of the aforementioned sections may be placed in a separate appendix section. Offerors are cautioned, however, that this does not constitute an invitation to submit large amounts of extraneous materials; appendices should be relevant and brief.

18.0 Non-Solicitation of Employees

Neither CalOptima nor CONTRACTOR shall solicit nor hire any personnel of the other during the Term of this Contract, or for a period of one year following the termination of this Contract, without the consent of the other party.

SECTION III: TECHNICAL AND PRICE PROPOSAL REQUIREMENTS

A. Technical Proposal Requirements

1.0 Corporate Capabilities

1.1 Qualifications and Experience

1.1.1 Provide a brief profile of the firm, including the types of services offered; the year founded; form of the organization (corporation, partnership, sole proprietorship); number, size and location of offices; number of employees.

1.1.2 Briefly describe the background of the company, including the formation, implementation of new business, sales, mergers, acquisitions, ownership, current lines of business and intended future lines of business. If applicable, indicate action to prevent disruption of current and/or new business.

1.1.3 Identify the senior management staff and their length of time with the company. Identify management staff that would be directly involved with the CalOptima contract and their length of time with the company.

1.1.4 Identify three (3) references of clients similar in scope and complexity to that of CalOptima. References shall include the name, title, email address, and telephone number of the person at the client organization who is most knowledgeable about the work.

1.1.5 Indicate any past or current material disputes including litigation with customers, provider groups, government entities, client groups and any other litigation with contingent liability of $500,000 or more. State the results or status of the dispute.

1.1.6 Is your company under investigation or being sued by any governmental agency? Has your company been barred from participation in a publicly-funded health program (such as Medicare or Medicaid)? If yes, provide a detailed explanation of the circumstances and status.

1.1.7 Provide details of any inquiry letters and/or negative audit results received from any state or federal agency or any outside business auditor.

1.1.8 Has your organization been audited in accordance with the Statements for Standards on Attestation Engagements (SSAE) 16 (formerly SAS 70 audit)? If yes, were any exceptions noted? If not audited, please explain.

1.1.9 If the respondent proposes to use subcontractor(s), it must describe any existing or ongoing relationships with the subcontractor(s); including project descriptions and the portions(s) of this RFP intended to be subcontracted

1.1.10 Identify subcontractors by company name, address, contact person, telephone number and project function and describe Offeror's experience working with each subcontractor.

2.0 Information Processing System (If you are proposing use of any systems, please complete)

2.1 Describe the current information processing system(s) used, highlighting features that ensure flexibility, timely updates of files, table-driven parameters, managed care orientation and timely, appropriate enhancements.

2.2 Describe the number, variety and location of processing platforms you use today. Are you planning a migration or consolidation of your system platforms? Describe the process, including testing and timeframes. Identify which platform(s) will be used to administer CalOptima's program.

2.3 Describe the security options related to user login and levels of security available by user profile.

2.4 Complete RFP Attachment 6: Security Questionnaire to describe your firm's standards for security, privacy, compliance and risk management and adherence to industry and government best practices.

2.5 Indicate the location and capacity of your data center(s). Describe your information systems disaster and recovery plans and identify applicable locations.

2.6 Quantify your application/system downtime monthly from January 1, 2015 to current. Identify scheduled and unscheduled downtime separately.

2.7 Do you operate your information processing system or do you have a subcontractor or vendor operate the system? If you are using a subcontractor(s), include the name(s).

2.8 Do you own the source code and manage all version upgrades, maintenance and application modifications internally? If not, use the table format below to identify entities and services performed.

System Subcontractors/Vendors					
Company Name	**Contact Name**	**Telephone**	**E-Mail**	**System/ Application Supported**	**Service Provided**

2.9 Can the software be customized to meet CalOptima's specific needs, including Programming/development integration, APIs and interfaces?

2.10 Can 18 months of past utilization from other systems be loaded and maintained within your system? Please describe any limitations.

2.11 How does the software access within and across the public Internet? Does the software have web-browser access? Describe the features of your member web portal.

2.12 Describe in detail all available web functionality and tools that will be made available to CalOptima through any resulting agreement.

2.13 Itemize required software and hardware to be installed/operational by CalOptima to achieve on-line connectivity to your organization. Will you supply all or some required software and hardware for on-line connectivity? Identify these items specifically and in the Price Proposal.

2.14 What is the process and format used to transfer data to CalOptima?

2.15 Describe the design, development and implementation processes used to update and modify the current information processing system software to maintain client requirements and industry standards.

- Are system updates done on a client-specific basis or on a cyclical basis for all or multiple clients?
- Confirm your commitment to maintain the software and to provide "bug" fixes and work-around solutions.
- Provide a summary of updates in-progress or planned. What abilities and timeframes will CalOptima have to test the upgrade prior to implementation?
- CalOptima expects to receive updates and new versions at no additional fee during the contract period. Confirm that updates and new versions will be made available on this basis to CalOptima.
- Indicate if CalOptima has the option of declining or postponing implementation of system changes or enhancements.

3.0 Financial Management

3.1 Provide evidence of financial stability sufficient to demonstrate reasonable stability and solvency appropriate to the requirements of this procurement:

3.1.1 If the respondent is a corporation that is required to report to the Securities and Exchange Commission, it must submit its two most recent SEC Forms 10K, Annual Reports.

3.1.2 If the respondent is *not* a corporation that is required to report to the Securities and Exchange Commission, it must submit its current financial statement plus previous two (2) years of audited financial reports including all supplements, management discussion and analysis, and actuarial options.

3.1.2.1 At a minimum, such financial statements and reports shall include: balance sheet; statement of income and expenses (also referred to as "statement of profit and loss"); statement of changes in financial position; cash flows; and capital expenditures.

3.1.3 If any change in ownership is anticipated during the twelve (12) months following the proposal due date, the respondent must describe the circumstances of such change and indicate when the change is likely to occur.

3.1.4 The respondent must identify any conditions (e.g., bankruptcy, pending litigation, planned office closures, impending merger) that may impede Offeror's ability to complete the project.

3.2 Include a copy of your billing invoice as part of your firms' proposal.

4.0 Proposed Staffing and Project Organization

4.1 Provide education, experience and applicable professional credentials of project staff.

4.2 Furnish brief resumes (not more than two [2] pages each) for the proposed Project Manager, Account Manager, and other key personnel.

4.3 Indicate adequacy of labor resources utilizing a table projecting the labor-hour allocation to the project by individual task.

4.4 Identify key personnel proposed to perform the work on the specified tasks and include major areas of subcontract work.

4.5 Include a project organization chart which clearly delineates communication/reporting relationships among the project staff.

4.6 Include a statement that key personnel will be available to the extent proposed for the duration of the project, acknowledging that no person designated as "key" to the project shall be removed or replaced without the prior written concurrence of CalOptima.

4.7 Identify the individuals who will be assisting with implementation, contract rollout, reporting and system questions. Include a list of qualifications and credentials for those individuals. Identify if any of these individuals continue in ongoing operation roles.

4.8 Describe the roles, responsibilities and deliverables of CalOptima and the Offeror during the implementation phase in a detailed work plan. The work plan must outline sequentially and describe the elements and activities that would be undertaken in completing the tasks; specify by name and job description, the person Offeror would assign to perform said task; the hourly rate of each person; rate for task identified; and include a schedule for completing the tasks in terms of elapsed weeks from the commencement date. Include details regarding the timeline needed before system is capable of being "live" for use after contract execution.

4.9 Describe in detail, the timeline dependencies for availability of required data feeds and interfaces to CalOptima systems in order to implement Offeror s system successfully based upon the timeline you propose.

4.10 What CalOptima resources are required by Offeror to meet the implementation timeframe?

B. Price Proposal Requirements

CalOptima is anticipating and hourly-rate bid for these types of services. If your firm would prefer to bill a different way, please submit that as a secondary offering to the RFP so we can review both options. If you are bidding for both services, please make sure your pricing is separate for each so we can evaluate all bidders for each specific service.

The successful Offeror shall not be allowed to invoice CalOptima throughout the duration of any resulting contract for any pricing not listed within the following pricing form. Pricing data contained in other areas of the Offeror's Proposal will not be considered.

C. Scope of Work

CalOptima is requesting proposals for two separate Health Homes Programs Select Services. They are:

- OBJECTIVE A - HHP Select Services - Housing Services
- OBJECTIVE B - HHP Select Services – Accompaniment Services

Interested bidders can bid on one of both of the select services below.

I. BACKGROUND

CalOptima contracts on a full or partial risk capitated basis with its delegated Health Maintenance Organizations and provider-sponsored organizations, known as Physician Hospital Consortia and Shared Risk Groups (jointly referred to as Health Networks), to provide care to approximately 75% of CalOptima members. Health Networks (HNs) are financially responsible according to their contract agreement to provide medically necessary services to their assigned members.

CalOptima serves the remaining members through a fee-for-service program known as "CalOptima Direct". CalOptima Direct network includes members who select to be in CalOptima Community Network (CCN) and members who are in specific categories (e.g., members with share of costs,

members with both Medicare and Medi-Cal) who are unable to select another network and would be served through the CalOptima Direct – Administrative program.

Health Homes Program (HHP)

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option. In California, Assembly Bill 361 (2013) authorizes implementation of the Health Home Program (HHP). Statewide, HHP will be implemented in selected counties with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. CalOptima, along with other selected counties in California are implementing HHP on a phased basis:

- No sooner than January 1, 2020 for CalOptima members with eligible chronic physical conditions and substance use disorder (SUD); and,
- No sooner than July 1, 2020 for members with Serious Mental Illness (SMI) and/or Seriously Emotional Distress (SED).[1]

DHCS has developed the "Health Homes for Patients with Complex Needs Program", including person-centered coordination to improve member outcomes through two objectives:

- Coordination of physical health services, mental health services, substance use disorder services, community-based LTSS, palliative care, and social support needs; and,
- Reduction of avoidable health care costs, including hospital admission/readmissions, Emergency Department visits, and nursing facility stays

DHCS is targeting the top 3-5% highest risk/utilizing Medi-Cal members with specific multiple chronic physical conditions aligned with certain acuity criteria, or SMI whose outcomes may improve through HHP interventions. In summary, CalOptima Medi-Cal members must meet criteria established by DHCS including both of the 'chronic condition' and 'acuity' requirements. CalOptima's Medicare and members dually eligible for Medicare and Medi-Cal can participate through referrals only if eligibility criteria are met. Part of the HHP eligible members may meet HHP eligibility criteria of 'Chronic Homeless'. Details on these eligibility requirements and exclusion criteria can be found in the HHP Program Guide available at the following link: https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx .

DHCS has identified the following six (6) HHP core services and expects these services to be available to all members enrolled in HHP:

1. Comprehensive Care Management;
2. Care Coordination;
3. Health Promotion;
4. Comprehensive Transitional Care;
5. Individual and Family Support Services; and,
6. Referral to Community and Social Supports, including housing navigation and sustainability services.

Pursuant to the DHCS Program Guide and All Plan Letter 18-012: Health Homes Program Requirements, Managed Care Plans (MCPs) will be responsible for overall administration, including development of the HHP network. HHP services will be coordinated through Community Based-Care Management Entities (CB-CMEs). HHP services will be provided primarily by a CB-CME under

[1] *Reference California SPA: 18-020 for SMI/SED definition at* https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-18-0020.pdf

a contract with CalOptima as the HHP Lead Entity. CB-CMEs will be responsible to coordinate with members, existing providers and other agencies.

CalOptima expects to be the CB-CME for members assigned to CalOptima Direct. Since HNs already provide most HHP services under their delegated contract, CalOptima has delegated CB-CME responsibilities to HNs for their assigned members. HNs may be permitted to subcontract for some select HHP services.

II. OBJECTIVE A – Housing Services

The purpose of this RFP is to solicit proposals from HHP select service providers, henceforth referred to as "OFFERORS", interested in contracting with CalOptima to provide Health Homes Program (HHP) ***housing navigation and sustainability services***. OFFEROR services shall be provided to CalOptima's Medi-Cal members enrolled in HHP program. For ease of administration, consistency and scale, CalOptima will require OFFEROR to make HHP services hereunder available to HNs, either through CalOptima's contract or a separate contract with individual HNs choosing to contract with OFFEROR for such services.

OFFEROR may also extend similar services, terms and conditions for other Medi-Cal programs supporting homeless population including, but not limited to, Whole Person Care (WPC). Such programs are administered either by CalOptima and/or other entities including the Orange County Health Care Agency (OCHCA).

CalOptima has the option to award contracts to a single or multiple OFFEROR(s), as needed in an effort to ensure the required coverage for its members. CalOptima has the option to retain any partial services in-house.

OFFEROR services shall be available to all CalOptima HHP enrolled members assigned to CalOptima Direct and any HHP enrolled member assigned to a CalOptima delegated HNs choosing to contract with OFFEROR for such services. OFFEROR will provide such services according to contract terms and expectations outlined by each contracted entity.

OFFEROR shall work with each contracted entity as applicable to ensure seamless access to the delivery of services and utilize processes and tools required by each individual entity.

Housing Navigation and Sustainability Services

The OFFEROR of Housing Services must have one or more HHP designated staff, referred to as a "Housing Navigator", who will assist members experiencing homelessness or at risk of homelessness, as directed by the contracted entity, as applicable. CalOptima will accept an application from the OFFEROR even if the OFFEROR can provide only one of the two services listed below.

The OFFEROR of Housing Services must provide one or both of the following:

- Individual Housing Transition Services and
- Individual Housing and Tenancy Sustaining Services

1. Individual Housing Transition Services to assist members with obtaining housing, such as individual outreach and assessments. These services include:

A. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;

B. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;

C. Assisting with the housing application process;

D. Assisting with the housing search process;

E. Identifying and securing resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;

F. Ensuring that the living environment is safe and ready for move-in;

G. Assisting in arranging for and supporting the details of the move; and

H. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

I. Coordinating with the County for those HHP members that are also in the County's Coordinated Entry System as there may be housing vouchers or programs identified for the client through this system.

2. Individual Housing and Tenancy Sustaining Services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

A. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;

a) Providing a plan for the client in recognition of these behaviors

b) Providing a plan for the landlord (who to call) if the behaviors are noted

B. Education and training on the roles, rights and responsibilities of the tenant and landlord;

C. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;

D. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;

E. Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;

F. Ensuring that the member is connected to social supports in the vicinity of their new community and that the other service providers connected with the member also know they are newly housed.

G. Assisting the client in accessing resources that may be necessary to obtain immediate need items including, but not limited to: toiletries, cleaning products, kitchen ware, bed, towels and linens, and refrigerator.

H. Assistance with the housing recertification process;

a) Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and

b) Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

III. Performance Guarantee

OFFEROR commits to the performance as expected and comply with the Corrective Action Plan provided by CalOptima if failure to meet the requirements of the contract. CalOptima reserves the right to pursue compliance actions in accordance with CalOptima Policy HH.2002 and HH.2005.

IV. Claims Processing and Reporting

OFFEROR or its staff shall never charge a member directly for any service hereunder nor shall OFFEROR ever accept a gratuity from a member for such services.

DHCS has established a HIPAA compliant HHP specific HCPCS code 'G9008' which is defined as "Coordinated care fee, physician coordinated care oversight services". OFFEROR agrees to comply with all DHCS claims submission timeliness requirements. OFFEROR agrees to adhere to the Provider Dispute Resolution process according to DHCS requirements and CalOptima's expectations.

OFFEROR will use the following modifiers to identify non-clinical staff services, in-person and telephonic/telehealth 'visits', and other HHP services such as case notes documentation, case conferences, and tenant supportive services.

OFFEROR will use HCPCS code with corresponding modifier for billing and reporting as follows:

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff, including case note documentation, case conferences and tenant supportive services	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed

V. Supplemental Information

CalOptima will evaluate OFFEROR based on all of the above requirements, service readiness as well as the responses to the "Supplemental Questionnaire" below. OFFEROR must respond as fully, accurately and completely as possible to each of the following questions as a part of its proposal response. OFFEROR shall respond with current state and how OFFEROR envisions meeting CalOptima's requirements.

All OFFERORs must provide information demonstrating:

A. Ability to capture, track and report the delivery of services described in Section II above.

B. Experience working with Medi-Cal members and/or similar racially, ethnically and culturally diverse populations.

C. Experience working with persons with multiple chronic conditions, SMI, and members experiencing homelessness.

D. Experience working with entities such as health networks, providers and county agencies and/or community-based organizations.

E. OFFEROR must submit their background check process for their staff for review by CalOptima.

F. Ability to hire, retain, manage and support paraprofessional or other staff with experience and knowledge of the population and processes specific to the designated service type as described below;

   a) If staff have insufficient required experience, please explain how OFFEROR would train staff to provide support services and participate in interdisciplinary care plans.

   b) Ability to provide services within two (2) business days of request.

   c) Ability to support members' need to speak in Orange County threshold languages.

G. Ability to receive, record and disseminate information about encounters with members , including services provided, findings, recommendations, referrals e.g., with member, health plan or other business partnerships involved in the care of members.

H. Confirm the ability to use tools created by CalOptima, to dedicate time for staff to train in use of these tools and to adopt internal processes (e.g., policies, desktops and reports) to track interventions, capture health outcomes, facilitate care planning and referral management.

I. Communication methods proposed to communicate with CalOptima and other contracted entities (such as health networks).

J. Current processes in place to handle urgent and emergent member grievances and coordinate resolution.

K. Experience working with Orange County Community Resources and target populations to ensure seamless access to the delivery of housing support services and to provide housing navigation services, not just referrals to housing, including:

   a) Working with individuals who are experiencing or may imminently be experiencing homelessness;
   b) Providing Individual Housing Transition Services, as described in Section II;
   c) Providing Tenancy Sustaining Services, as described in Section II;
   d) Working with Orange County housing agencies, permanent housing providers, including supportive housing providers, and other community-based organizations, Coordinated Entry process.
   e) Describe tools or standards that staff will follow to report or document the notes after services provided to each member.
   f) Describe OFFEROR's ability to be flexible with contracted entities to provide the same services with various expectations.

VI. OBJECTIVE B – Accompaniment Services

The purpose of this RFP is to solicit proposals from HHP select service providers, henceforth referred to as "OFFERORS", interested in contracting with CalOptima to provide Health Homes Program (HHP) ***accompaniment services.*** OFFEROR services shall be provided to CalOptima's Medi-Cal members enrolled in HHP program. For ease of administration, consistency and scale, CalOptima will require OFFEROR to make HHP services hereunder available to HNs, either through CalOptima's contract or a separate contract with individual HNs choosing to contract with OFFEROR for such services.

CalOptima has the option to award contracts to a single or multiple OFFEROR(s), as needed to ensure the required coverage for its members. CalOptima has the option to retain any partial services in-house.

OFFEROR services shall be available to all CalOptima HHP enrolled members assigned to CalOptima Direct and any HHP enrolled member assigned to a CalOptima delegated HNs choosing to contract with OFFEROR for such services. OFFEROR will provide such services according to contract terms and expectations outlined by each contracted entity.

OFFEROR shall work with each contracted entity as applicable to ensure seamless access to the delivery of services and utilize processes and tools required by each individual entity.

Accompaniment:

The OFFEROR of Accompaniment Service will be required to provide 'accompaniment' services to HHP members for medically necessary appointments in a timely manner (as described in the CalOptima Provider Manual, Section M6) as approved and requested by CalOptima and/or Health Networks according to the expectations outlined below:

A. Outreach to member in advance of scheduled appointment to coordinate, including to obtain appointment date and time, and to provide information on accompaniment process, what to expect at the appointment, identification of potential questions.
    a) On a case by case basis, as requested by CalOptima and/or Health Networks, discuss in advance of an appointment for special instructions.
    b) Contact member the business day prior to the appointment for reminder and confirmation of the appointment.
B. Provide same-day services to a member who needs accompaniment to an unplanned service such as urgent care or emergency department.
C. Traveling with member to an appointment or meeting member at provider office based upon member's need.
D. Attending appointment with member at clinical provider office as requested.
E. Members are expected to arrange their own transportation or request CalOptima to provide non-medical transportation to the appointment. OFFEROR is not permitted to drive member to the appointment or allow member to drive OFFEROR (staff) to the appointment.
F. CalOptima will identify HHP member for accompaniment services for specific appointment and notify OFFEROR.
G. CalOptima expects that most accompaniment will take place within Orange County.

a) CalOptima prefers OFFEROR to provide accompaniment throughout Orange County; CalOptima will accept proposals for services on a regional basis;

b) Out-of-county requests outside the ten (10) miles of Orange County may be required on a case-by-case basis.

H. OFFEROR must send to member and CalOptima, no later than 2 business days following the date of the appointment, a summary report of the discussion, questions raised, next appointment (if any) member next steps, and any referrals for follow-up by CalOptima. CalOptima and Health Network will provide standard form that OFFEROR will be required to complete.

I. OFFEROR must participate in care team meetings and implementing care plan, as requested. CalOptima and Health Network will notify OFFEROR and conduct Care team meetings outside of the member appointments.

VII. Performance Guarantee

OFFEROR commits to the performance as expected and comply with the Corrective Action Plan provided by CalOptima if failure to meet the requirements of the contract. CalOptima reserves the right to pursue compliance actions in accordance with CalOptima Policy HH.2002 and HH.2005.

VIII. Claims/Reimbursement Processing and Reporting

OFFEROR or its staff shall never charge a member directly for any service hereunder nor shall OFFEROR ever accept a gratuity from a member for such services.

DHCS has established a HIPAA compliant HHP specific HCPCS code 'G9008' which is defined as "Coordinated care fee, physician coordinated care oversight services". OFFEROR agrees to comply with all DHCS claims submission timeliness requirements. OFFEROR agrees to adhere to the Provider Dispute Resolution process according to DHCS requirements and CalOptima's expectations.

OFFEROR will use the following modifiers to identify non-clinical staff services, in-person and telephonic/telehealth 'visits', and other HHP services such as case notes documentation, case conferences, and driving to appointments.

OFFEROR will use HCPCS code with corresponding modifier for billing and reporting as follows:

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Non-Clinical Staff, including accompaniment	G9008	U4	15 Minutes equals 1 UOS; Multiple UO allowed
Phone/Telehealth: Provided by Non-Clini Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UO allowed
Other Health Home Services: Provided by Non-Clinical Staff, including participation in ICT, care planning and driving to appointments.	G9008	U6	15 Minutes equals 1 UOS; Multiple UO allowed

IX. Supplemental Information

CalOptima will evaluate OFFEROR based on all of the above requirements, service readiness, as well as the responses to the "Supplemental Questionnaire" below. OFFEROR must respond as fully, accurately

and completely as possible to each of the following questions as a part of its proposal response. OFFEROR shall respond with current state and how OFFEROR envisions meeting CalOptima's requirements.

All OFFERORs must provide information demonstrating:

A. Ability to capture, track and report the delivery of services described in Section II above.

B. Experience working with Medi-Cal members and/or similar population racially, ethnically and culturally diverse populations.

C. Experience working with persons with multiple chronic conditions, Substance Use Disorders and/or Serious Mental Illness.

D. Experience working with entities such as health networks, providers and county agencies and/or community-based organizations.

E. OFFEROR must submit their background check process for their staff for review by CalOptima.

F. Ability to hire, retain, manage and support paraprofessional or other staff with experience and knowledge of the population and processes specific to the designated service type as described below;

   a) If staff have insufficient required experience, please explain how OFFEROR would train staff to provide support services and participate in interdisciplinary care plans.

   b) Ability to provide services within two (2) business days of request.

   c) Ability to support members' need to speak in Orange County threshold languages.

G. Ability to receive, record and disseminate information about encounters with members, including services provided, findings, recommendations, referrals e.g., with member, health plan or other business partnerships involved in the care of members.

H. Confirm the ability to use tools created by CalOptima, to dedicate time for staff to train in use of these tools and to adopt internal processes (e.g., policies, desktops and reports) to track interventions, capture health outcomes, facilitate care planning and referral management.

I. Communication methods proposed to communicate with CalOptima and other contracted entities (such as health networks).

J. Current processes in place to handle urgent and emergent member grievances and coordinate resolutions.

K. Experience in providing accompaniment to appointments or direct face-to-face services to members related to physical health, mental health and/or social determinants of health services.

L. OFFEROR's process/ability to assign the designated staff to accompany the same member to future appointments.

M. How OFFEROR selects staff to accompany member (e.g., geographical, language/culture, type appointment) and, if applicable, how processes will be modified for HHP.

N. How staff currently prepares for an appointment/face-to-face session and what information may be needed from CalOptima.

O. Tools or standards staff will follow to report or document the notes after accompaniment event.

P. Describe OFFEROR's ability to be flexible with contracted entities to provide the same services with various expectations from contracted entities.

RFP Attachment 1: Mandatory Offeror Acknowledgement

ACKNOWLEDGEMENT

In signing this Proposal, Offeror acknowledges receipt of the RFP 19-021A and the following addenda, if any (expand list as necessary):

Addendum no. _____ , Received on: _____

Addendum no. _____ , Received on: _____

Addendum no. _____ , Received on: _____

I acknowledge receipt of RFP 19-021A and addenda cited.

I hereby certify on behalf of _____ that the contents of this Proposal are, to the best of my ability, completely in compliance with all requirements of the RFP 19-021A and the terms and conditions of the contract, without exceptions, other than those expressly listed and explained in this Proposal. This Proposal is an irrevocable offer, which shall remain in full force and effect for 150 calendar days after the Proposal due date.

Company Name: _____

Address: _____

Telephone Number: _____

Signature Of Person Authorized To Bind Offeror: _____

Signatory's Name And Title: _____

Date Signed: _____

RFP Attachment 2: Mandatory Non-Collusion Affidavit

NON-COLLUSION AFFIDAVIT

_____, being first duly sworn, deposes and says that he or she is_____ of _____ the party making the foregoing Proposal that the Proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the Proposal is genuine and not collusive or sham; that the Offeror has not directly or indirectly induced or solicited any other Offeror to put in a false or sham Proposal and has not directly or indirectly colluded, conspired, connived, or agreed with any Offeror or anyone else to put in a sham Proposal, or that anyone shall refrain from bidding; that the Offeror has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the Proposal price of the Offeror or any other Offeror or to fix any overhead, profit, or cost element of the Proposal price, or of that of any other Offeror, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the Proposal are true; and, further, that the Offeror has not, directly or indirectly, submitted his or her Proposal price or any breakdown thereof, or the contents thereof, or divulged information or date relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, bid depository, or to any member or agent thereof to effectuate a collusive or sham bid.

_____ _____

Signature Date

_____

Title

RFP Attachment 3: Offeror Eligibility Certification

OFFEROR ELIGIBILITY CERTIFICATION

Offeror certifies, to the best of its knowledge and belief, that that offeror and/or any of its Principals:

A. Are ☐, are not ☐ presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contract by any Federal agency or from participating in any Federal healthcare programs;

B. Have ☐, have not ☐, within a ten (10)-year period preceding this offer, been convicted of or had a civil judgement rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) contract or subcontract; violation of Federal or State antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, violating Federal criminal tax laws, or receiving stolen property;

C. Are ☐, are not ☐ presently indicted for, or otherwise criminally or civilly charged by a governmental entity with, commission of any of the offenses enumerated in Section (B); and

D. Have ☐, have not ☐, within a ten (10)-year period preceding this offer, been notified of any delinquent Federal taxes in an amount that exceeds $3,000 for which the liability remains unsatisfied.

For purposed of this certification, "Principal" means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (e.g. general manager, plant manager, head of a division or business segment and similar positions).

By:
Name: _____
Title: _____
Company: _____
Date: _____

Revised February 2019

RFP Attachment 4: CalOptima Sample Contract and Sample BAA

Click on icon below for Attachment 4.


19-021A - Non-Medical Ancilla


19-021 - HHP Select Services - Sample BA

RFP Attachment 5: Request to Negotiate Contract/BAA Terms

Click on icon below for Attachment 5.



Request to
Negotiate Contract T

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RFP Attachment 6: Security Questionnaire

Offeror is required to certify that it (and any proposed subcontractors) comply with the following security provisions, as required in this RFP. Offeror must complete the following questionnaire and explain how you propose to meet any exceptions.

1. Information Security Program, Policy & Procedures

    a. Do you have documented information security policies and procedures? If so, list the titles of each policy.

    b. Does your security policy meet HIPAA requirements? Has it been audited by external auditor, and if so, when was it last audited?

    c. Do you have a formal information classification procedure? Describe in particular, how would patient data be categorized?

2. Personnel Security

    a. Has your organization formally appointed a central point of contact for security coordination, e.g. a designated information security officer and/or privacy officer? If so, whom, and what is their position within the organization?

    b. Does your organization perform background checks to examine and access an employees' or contractor's work and criminal history?

    c. Do you work with third parties, such as IT service providers that have access to or store your sensitive information?

    d. In the event of a security incident with one of your third-party vendors, what is the policy for alert notifications, timeline for resolution, etc? If such a process exists, provide the document as part of your response as Proposal Exhibit: Third-party Security Event Notices

3. Network Security

    a. Provide a diagram of your firms network configuration. Has your IT vendor provided information regarding how your sensitive information systems are protected?

    b. Are systems and networks that host, process and or transfer sensitive information "protected" (isolated or separated) from other systems and/or networks?

    c. Are internal and external networks separated by firewalls with access policies and rules?

    d. Is there a standard approach for protecting network devices to prevent unauthorized access/network related attacks and data-theft?

    e. Is sensitive information transferred to external recipients? If so, what controls are in place to protect sensitive information when transferred (e.g. with encryption?)

    f. How does your firm manage vulnerabilities and threats? How often are Vulnerability Assessments performed?

g. What is the remediation process for vulnerabilities that are discovered?

h. Are third party connections to your network monitored and reviewed to confirm authorized access and appropriate usage? How often does your firm attest third party network connectivity?

i. What network security tools do you have in place? (i.e., DLP, IPS/IDS, Advanced Malware Detection, Web Content Filtering, etc.).

j. Describe your methodology for tuning your security tools (i.e., DLP, IPS, Advanced Malware Detection, Web Content Filtering, etc.) How do you ensure your security tools are effective and up to date?

k. Does your firm conduct annual internal and external penetration tests by a 3rd party?

4. Logical Access

a. Do you have a formal access authorization process based on "least privilege" (employees are granted the least amount of access possible in order to perform their assigned duties) and need to know (access permissions are granted based upon the legitimate business need of the user to access the information)?

b. How are systems and applications configured to allow access only to authorized individuals?

c. Is there a list maintained of authorized users with access (administrative access) to operating systems?

d. Does your firms system support mobile devices? If so, describe in detail how your firm can control mobile device access.

e. Is sensitive information (e.g. social security numbers) masked or removed from, or encrypted within, documents and or websites before it is distributed?

f. Is software installation restricted for desktops, laptops and servers? What type of system hardening does your firm perform?

g. Is access to source application code restricted? If so, how? Is a list of authorized user maintained? How does your firm protect its source code?

h. Are user IDs for your system uniquely identifiable?

i. Do you have a process to review user accounts and related access? How does your firm do user attestation?

5. Operations Management

a. Has antivirus software been deployed and installed on your computers and supporting systems (e.g., desktops, servers and gateways?)

b. Are systems and networks monitored for security events? If so, describe monitoring in detail.

c. Do procedures exist to protect documents, computer media (e.g., tapes, disks, CD-ROMs, etc.) from unauthorized disclosure, modification, removal, and destruction? Is sensitive data encrypted when stored on laptop, desktop and server hard drives, flash drives, backup tapes, etc.?

d. Does your firm send backup tapes to an offsite vendor? If so, name the vendor.

e. Are there security procedures for the decommissioning (replacement) of IT equipment and IT storage devices which contain or process sensitive information? If so, please describe.

f. Are development, test and production environments separated from operational IT environments to protect production (actively used) applications from inadvertent changes or disruption?

g. Are duties separated, where appropriate, to reduce the opportunity for unauthorized modification, unintentional modification or misuse of the organization's IT assets?

h. Do formal change management procedures exist for networks, systems, desktops, software releases, deployments, and software vulnerability (e.g., Virus or Spyware) patching activities?

6. Incident Management and Investigations

a. Is a formalized and documented process in place for incidents and investigations?

b. How do you identify, respond to and mitigate suspected or known security incidents?

c. During the investigation of a security incident, is evidence properly collected and maintained?

d. Are incidents identified, investigated, and reported according to applicable legal requirements?

e. How are incidents escalated and communicated?

RFP Attachment 7: Campaign Contribution Disclosure

CALOPTIMA LEVINE ACT DISCLOSURE STATEMENT

California Government Code section 84308, commonly referred to as the "Levine Act," precludes an Officer of a local government agency from participating in the award of a contract if he or she receives any political contributions totaling more than $250 in the 12 months preceding the pendency of the contract award, and for three months following the final decision, from the person or company awarded the contract. This prohibition applies to contributions to the Officer, or received by the Officer on behalf of any other Officer, or on behalf of any candidate for office or on behalf of any committee. The Levine Act also requires disclosure of such contributions by a party to be awarded a specified contract. Please refer to Attachment A to this Statement for the complete statutory language.

Current members of the CalOptima Board of Directors are:

Ria Berger	Ron DiLuigi	Andrew Do	Dr. Nikan Khatibi
Alexander Nguyen, M.D.	Lee Penrose	Richard Sanchez	J. Scott Schoeffel
Michelle Steel	Paul Yost, M.D.	Doug Chaffee (Alternate)	

1. Have you or your company, or any agent on behalf of you or your company, made any political contributions of more than $250 to any CalOptima Director(s) in the 12 months preceding the date of the issuance of this request for proposal or request for qualifications?

___ YES ___ NO

If yes, please identify the Director(s):

2. Do you or your company, or any agency on behalf of you or your company, anticipate or plan to make any political contributions of more than $250 to any CalOptima Director(s) between the date of issuance of this request for proposals and the award of the contract, or in the three months following the award of the contract?

___ YES ___ NO

If yes, please identify the Director(s):

Answering yes to either of the two questions above does not preclude CalOptima from awarding a contract to your firm. It does, however, preclude the identified Director(s) from participating in the contract award process for this contract.

_____ DATE

_____ (SIGNATURE OF AUTHORIZED OFFICIAL)

_____ (TYPE OR WRITE APPROPRIATE NAME, TITLE)

_____ (TYPE OR WRITE NAME OF COMPANY)

CALOPTIMA LEVINE ACT DISCLOSURE STATEMENT
Attachment A

California Government Code Section 84308

(a) The definitions set forth in this subdivision shall govern the interpretation of this section.

(1) "Party" means any person who files an application for, or is the subject of, a proceeding involving a license, permit, or other entitlement for use.

(2) "Participant" means any person who is not a party but who actively supports or opposes a particular decision in a proceeding involving a license, permit, or other entitlement for use and who has a financial interest in the decision, as described in Article 1 (commencing with Section 87100) of Chapter 7. A person actively supports or opposes a particular decision in a proceeding if he or she lobbies in person the officers or employees of the agency, testifies in person before the agency, or otherwise acts to influence officers of the agency.

(3) "Agency" means an agency as defined in Section 82003 except that it does not include the courts or any agency in the judicial branch of government, local governmental agencies whose members are directly elected by the voters, the Legislature, the Board of Equalization, or constitutional officers. However, this section applies to any person who is a member of an exempted agency but is acting as a voting member of another agency.

(4) "Officer" means any elected or appointed officer of an agency, any alternate to an elected or appointed officer of an agency, and any candidate for elective office in an agency.

(5) "License, permit, or other entitlement for use" means all business, professional, trade and land use licenses and permits and all other entitlements for use, including all entitlements for land use, all contracts (other than competitively bid, labor, or personal employment contracts), and all franchises.

(6) "Contribution" includes contributions to candidates and committees in federal, state, or local elections.

(b) No officer of an agency shall accept, solicit, or direct a contribution of more than two hundred fifty dollars ($250) from any party, or his or her agent, or from any participant, or his or her agent, while a proceeding involving a license, permit, or other entitlement for use is pending before the agency and for three months following the date a final decision is rendered in the proceeding if the officer knows or has reason to know that the participant has a financial interest, as that term is used in Article 1 (commencing with Section 87100) of Chapter 7. This prohibition shall apply regardless of whether the

officer accepts, solicits, or directs the contribution for himself or herself, or on behalf of any other officer, or on behalf of any candidate for office or on behalf of any committee.

(c) Prior to rendering any decision in a proceeding involving a license, permit or other entitlement for use pending before an agency, each officer of the agency who received a contribution within the preceding 12 months in an amount of more than two hundred fifty dollars ($250) from a party or from any participant shall disclose that fact on the record of the proceeding. No officer of an agency shall make, participate in making, or in any way attempt to use his or her official position to influence the decision in a proceeding involving a license, permit, or other entitlement for use pending before the agency if the officer has willfully or knowingly received a contribution in an amount of more than two hundred fifty dollars ($250) within the preceding 12 months from a party or his or her agent, or from any participant, or his or her agent if the officer knows or has reason to know that the participant has a financial interest in the decision, as that term is described with respect to public officials in Article 1 (commencing with Section 87100) of Chapter 7.

If an officer receives a contribution which would otherwise require disqualification under this section, returns the contribution within 30 days from the time he or she knows, or should have known, about the contribution and the proceeding involving a license, permit, or other entitlement for use, he or she shall be permitted to participate in the proceeding.

(d) A party to a proceeding before an agency involving a license, permit, or other entitlement for use shall disclose on the record of the proceeding any contribution in an amount of more than two hundred fifty dollars ($250) made within the preceding 12 months by the party, or his or her agent, to any officer of the agency. No party, or his or her agent, to a proceeding involving a license, permit, or other entitlement for use pending before any agency and no participant, or his or her agent, in the proceeding shall make a contribution of more than two hundred fifty dollars ($250) to any officer of that agency during the proceeding and for three months following the date a final decision is rendered by the agency in the proceeding. When a closed corporation is a party to, or a participant in, a proceeding involving a license, permit, or other entitlement for use pending before an agency, the majority shareholder is subject to the disclosure and prohibition requirements specified in subdivisions (b), (c), and this subdivision.

(e) Nothing in this section shall be construed to imply that any contribution subject to being reported under this title shall not be so reported.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

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- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

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	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

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A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II. HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III. HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in at least one of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to

be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

Acuity Eligibility Criteria

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above.

MCPs must have a process to verify eligibility as part of their internal TEL production and enrollment process. MCPs can do this through reviews of the MCPs data, to the extent that data is available, and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

The TEL provides a list of potentially eligible members. MCPs may use this file in several ways. Examples include:

1. After applying the DHCS approved MCP prioritization policy to the TEL, the MCP may directly assign members on the TEL to CB-CMEs. In this scenario, the MCP delegates eligibility verification to the CB-CMEs.

2. MCPs may use their own data to develop eligibility lists, adding members from the TEL who qualify through their SMI or Physical Health/SUD chronic condition diagnoses for whom the MCP may lack utilization data.

MCPs may also use other strategies approved by DHCS. In all cases, MCPs must ensure that the approved MCP prioritization logic is applied to all assigned members to guide MCP and/or CB-CME outreach.

MCPs are advised to deprioritize members from outreach whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions.

For payment purposes, the member may be enrolled for one month while eligibility is verified. After one month, payment is not available until eligibility is determined. If determined ineligible, the member will be disenrolled.

Homeless Eligibility Criteria

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section*

50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her residence." For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

People Excluded from Targeted Engagement List

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
    1) Engage the member in the HHP and their own care
    2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
    3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
    4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
    1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
    2) How trauma-informed care best practices will be utilized?
    3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
    1) How the HAP is shared with other providers and if it can be shared electronically; and
    2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
    1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
    2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support

- Working with the member to implement their HAP
- Assisting the member in navigating health, behavioral health, and social services systems, including housing
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Identifying barriers to the member's treatment and medication management adherence
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Assisting in attainment of the member's goals as described in the HAP
- Encouraging the member's decision making and continued participation in HHP
- Accompanying members to appointments as needed

2) Coordination

- Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
- Creating and promoting linkages to other services and supports
- Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
    i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
    ii. Tier 1 – two in-person visits per month
    iii. Tier 2 – 1 in-person visit per month
    iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V. Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.
f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.
g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.
h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.
i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.
b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies
b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers
c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges
d. Track and share data with CB-CMEs regarding each member's health history
e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of

the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:
      a. Letter to member followed by phone call to member
      b. Phone call to member, outreach to care delivery partners and social service partners

c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity

for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;

- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities. The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members

must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

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- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

SAMPLE

B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or
3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or
3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or
3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

- Nursing Facility Residents
- Hospice Recipients
- Members with TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or AHF
- Members in Cal MediConnect

b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

- Dually eligible members
- Members in CCS or GHPP
- Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Filler	Filler	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Filler	Filler	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

D. Appendix D – Readiness Requirements and Checklist

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI– MHP-MOU: Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

SMI Network: Section III – Network (Deliverables #6.2a and 6.2b)

Group 1: San Francisco Counties

Deliverable Due Dates		Deliverable Approval Dates
P&Ps:	3/1/18	5/1/18
Network:	5/1/18	6/1/18
SMI Deliverables:	11/1/18	12/1/18

Group 2: Riverside, and San Bernardino Counties

Deliverable Due Dates		Deliverable Approval Dates
Network:	11/1/18	12/1/18
SMI MHP-MOU:	2/1/19	3/1/19
SMI Network:	5/1/19	6/1/19

Group 3.1: Imperial, and Santa Clara Counties

Deliverable Due Dates		Deliverable Approval Dates
Network:	4/1/19	6/1/19
SMI MHP-MOU:	7/1/19	8/1/19
SMI Network:	10/1/19	12/1/19

Group 3.2: Alameda, Kern, Los Angeles, Sacramento, San Diego, and Tulare Counties

Deliverable Due Dates		Deliverable Approval Dates
Network:	5/1/19	6/1/19
SMI MHP-MOU:	8/1/19	9/1/19
SMI Network:	11/1/19	12/1/19

Group 4: Orange County

Deliverable Due Dates		Deliverable Approval Dates
Network:	11/1/19	12/1/19
SMI MHP-MOU:	2/1/20	3/1/20
SMI Network:	5/1/20	6/1/20

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.

For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.

When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.

- Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

4.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

4.2 Submit the Health Action Plan (HAP) template.

4.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:

- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

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III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – SMI**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members

with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

□ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

□ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

□ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

□ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

□ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

□ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

□ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

□ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

Managed Care Plan	Signature of Authorized Representative
Date	Name of Authorized Representative
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	**HCPCS Code**	**Modifier**	**Units of Service (UOS)**
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Telehealth and Group Visits

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

F. Appendix F – Evidence of Coverage Template

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Do not make changes to this template. Reports that contain changes to this template will be rejected and must be resubmitted.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2– April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4– October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example:

MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

All report revisions are subject to DHCS review and approval.

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx.to your designated folder in the "DHCS-MCQMD-Data/MCP/Monitoring" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Homeless and Chronically Homeless: see CA Welfare & Institution Code § 14127(e)

Housing Services:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. **For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information**.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

1. Health Home Program Enrollment Reporting
Note: **Only report one (1) exclusionary reason per member excluded from the Program.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Column Name	Explanation
Number MCP excluded because not eligible - well-managed (Column C)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.
Number MCP excluded because declined to participate (Column D)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP.
Number MCP excluded because of unsuccessful engagement (Column E)	Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment.

Column Name	Explanation
Number MCP excluded because duplicative program (Column F)	Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following: 1. Duplicative Programs a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH) b. Targeted Case Management (TCM) – County, not Mental Health TCM 2. Programs excluded by DHCS Policy a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month. b. Hospice 3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy
Number MCP excluded because unsafe behavior or environment (Column G)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

Column Name	Explanation
Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)	Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following: a. Fee-For-Service b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF) c. Member is deceased
Number externally referred but excluded (Column I)	Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H.
Average monthly number of dedicated care coordination FTEs (Column J)	Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number.

2. Health Home Program Member Activity Reporting

Column Name	Explanation
Plan Code – Plan Name – County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
Number initial HAP completed within 90 days (Column C)	Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment.
Number initial HAP completed (Column D)	Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter.

3. Health Home Program Member-Level Detail Reporting
Note: This tab captures all members enrolled in HHP. Additionally, this tab reports on those members who are homeless/at risk of homelessness and received housing support services during the quarter. If a member was disenrolled during the quarter, enter the disenrollment date. The disenrolled member should not be reported in subsequent quarters unless the member reenrolls. This tab is to be submitted quarterly.

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported. For example, the 4th quarter of 2019 will be entered as 2019 Q4.
Member CIN (Column C)	Enter the Member's Client Identification Number (CIN).
Member Last Name (Column D)	Enter the Member's Last Name.
Member First Name (Column E)	Enter the Member's First Name.
Member Date of Birth (DOB) (Column F)	Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY.
SPA 1 (PHYS-SUD) or SPA 2 (SMI) Member (Column G)	Indicate which State Plan Amendment (SPA) the HHP member was enrolled under. Enter "1" or "2."
Dual Member (Column H)	Indicate the member's "Dual" status (having both Medicare & Medi-Cal) as of the last day of the quarter. If the member was disenrolled during the quarter, report as of their last date of enrollment. Enter "Dual" or "Non-Dual."
Externally Referred and Enrolled (Column I)	Indicate whether the HHP enrolled member was referred into the program. Enter "Yes" or "No." The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Indicate "Yes" if, upon MCP review and evaluation, the individual is approved for HHP and enrolled.

Column Name	Explanation
Enrollment Date (Column J)	Enter the Member's Enrollment Date using format MM/DD/YY.
Date of Disenrollment (if applicable) (Column K)	Enter the Member's Date of Disenrollment using format MM/DD/YY. If the Member remains enrolled in the program, leave this cell blank. The disenrolled member should not be reported in subsequent reports unless the member reenrolls.
Member was Homeless or at Risk for Homelessness During The Quarter(Column L)	Indicate whether the member met the Federal definition of Homeless or required tenancy sustaining services at any point during the quarter. Enter “Yes" or "No."
Member Received Housing Services During the Quarter (Column M)	Indicate whether the member received housing services at any point during the quarter. Enter "Yes" or "No."
Member was Homeless At Any Point During Their Enrollment in HHP (Column N)	Indicate whether the member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No."
Members no longer Homeless On Last Day of the Quarter (Column O)	Indicate whether the member no longer meets the Federal definition of Homeless as of the last day of the quarter. If the member was disenrolled during the quarter, report as of their last date of enrollment. Enter "Yes" or "No." Leave Blank if the member was never Homeless.

4. Health Home Program Network Reporting

Column Name	Explanation
Plan Code – Plan Name – County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member’s assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
CB-CME NPI # (Column C)	Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for

Column Name	Explanation
	that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors.
Capacity for each CB-CME (Column D)	Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter.

5. Health Home Program Annual CMS Core Measures Reporting

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. The first annual quality reporting for the CBP measure will begin in Measurement Year (MY) 2020 and will be submitted in Reporting Year (RY) 2021 with the Q1 Report, due May 31, 2021. There is no partial-year reporting for the Health Homes Core Set of Health Care Quality Measures.

DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the following Technical Specifications and Resource Manual link from CMS.

https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/FFY-19-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

Note: **This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year for the data reported: Year.
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 -	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator

Column Name	Explanation
numerator (Column M)	
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator

6. Health Home Program Reporting Comments

Column Name	Explanation
Comments (Column A)	Enter any relevant information pertaining to the submitted report and the data it contains.

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41

HHP Eligible Condition Diagnosis Codes

Hypertension
I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,
Liver Disease
K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4
TBI
S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

S06.346S, S06.347A, S06.347D, S06.347S, S06.348A, S06.348D, S06.348S, S06.349A, S06.349D, S06.349S, S06.350A, S06.350D, S06.350S, S06.351A, S06.351D, S06.351S, S06.352A, S06.352D, S06.352S, S06.353A, S06.353D, S06.353S, S06.354A, S06.354D, S06.354S, S06.355A, S06.355D, S06.355S, S06.356A, S06.356D, S06.356S, S06.357A, S06.357D, S06.357S, S06.358A, S06.358D, S06.358S, S06.359A, S06.359D, S06.359S, S06.360A, S06.360D, S06.360S, S06.361A, S06.361D, S06.361S, S06.362A, S06.362D, S06.362S, S06.363A, S06.363D, S06.363S, S06.364A, S06.364D, S06.364S, S06.365A, S06.365D, S06.365S, S06.366A, S06.366D, S06.366S, S06.367A, S06.367D, S06.367S, S06.368A, S06.368D, S06.368S, S06.369A, S06.369D, S06.369S, S06.370A, S06.370D, S06.370S, S06.371A, S06.371D, S06.371S, S06.372A, S06.372D, S06.372S, S06.373A, S06.373D, S06.373S, S06.374A, S06.374D, S06.374S, S06.375A, S06.375D, S06.375S, S06.376A, S06.376D, S06.376S, S06.377A, S06.377D, S06.377S, S06.378A, S06.378D, S06.378S, S06.379A, S06.379D, S06.379S, S06.380A, S06.380D, S06.380S, S06.381A, S06.381D, S06.381S, S06.382A, S06.382D, S06.382S, S06.383A, S06.383D, S06.383S, S06.384A, S06.384D, S06.384S, S06.385A, S06.385D, S06.385S, S06.386A, S06.386D, S06.386S, S06.387A, S06.387D, S06.387S, S06.388A, S06.388D, S06.388S, S06.389A, S06.389D, S06.389S, S06.4X0A, S06.4X0D, S06.4X0S, S06.4X1A, S06.4X1D, S06.4X1S, S06.4X2A, S06.4X2D, S06.4X2S, S06.4X3A, S06.4X3D, S06.4X3S, S06.4X4A, S06.4X4D, S06.4X4S, S06.4X5A, S06.4X5D, S06.4X5S, S06.4X6A, S06.4X6D, S06.4X6S, S06.4X7A, S06.4X7D, S06.4X7S, S06.4X8A, S06.4X8D, S06.4X8S, S06.4X9A, S06.4X9D, S06.4X9S, S06.5X0A, S06.5X0D, S06.5X0S, S06.5X1A, S06.5X1D, S06.5X1S, S06.5X2A, S06.5X2D, S06.5X2S, S06.5X3A, S06.5X3D, S06.5X3S, S06.5X4A, S06.5X4D, S06.5X4S, S06.5X5A, S06.5X5D, S06.5X5S, S06.5X6A, S06.5X6D, S06.5X6S, S06.5X7A, S06.5X7D, S06.5X7S, S06.5X8A, S06.5X8D, S06.5X8S, S06.5X9A, S06.5X9D, S06.5X9S, S06.6X0A, S06.6X0D, S06.6X0S, S06.6X1A, S06.6X1D, S06.6X1S, S06.6X2A, S06.6X2D, S06.6X2S, S06.6X3A, S06.6X3D, S06.6X3S, S06.6X4A, S06.6X4D, S06.6X4S, S06.6X5A, S06.6X5D, S06.6X5S, S06.6X6A, S06.6X6D, S06.6X6S, S06.6X7A, S06.6X7D, S06.6X7S, S06.6X8A, S06.6X8D, S06.6X8S, S06.6X9A, S06.6X9D, S06.6X9S, S06.810A, S06.810D, S06.810S, S06.811A, S06.811D, S06.811S, S06.812A, S06.812D, S06.812S, S06.813A, S06.813D, S06.813S, S06.814A, S06.814D, S06.814S, S06.815A, S06.815D, S06.815S, S06.816A, S06.816D, S06.816S, S06.817A, S06.817D, S06.817S, S06.818A, S06.818D, S06.818S, S06.819A, S06.819D, S06.819S, S06.820A, S06.820D, S06.820S, S06.821A, S06.821D, S06.821S, S06.822A, S06.822D, S06.822S, S06.823A, S06.823D, S06.823S, S06.824A, S06.824D, S06.824S, S06.825A, S06.825D, S06.825S, S06.826A, S06.826D, S06.826S, S06.827A, S06.827D, S06.827S, S06.828A, S06.828D, S06.828S, S06.829A, S06.829D, S06.829S, S06.890A, S06.890D, S06.890S, S06.891A, S06.891D, S06.891S, S06.892A, S06.892D, S06.892S, S06.893A, S06.893D, S06.893S, S06.894A, S06.894D, S06.894S, S06.895A, S06.895D, S06.895S, S06.896A, S06.896D, S06.896S, S06.897A, S06.897D, S06.897S, S06.898A, S06.898D, S06.898S, S06.899A, S06.899D, S06.899S, S06.9X0A, S06.9X0D, S06.9X0S, S06.9X1A, S06.9X1D, S06.9X1S, S06.9X2A, S06.9X2D, S06.9X2S, S06.9X3A, S06.9X3D, S06.9X3S, S06.9X4A, S06.9X4D, S06.9X4S, S06.9X5A, S06.9X5D, S06.9X5S, S06.9X6A, S06.9X6D, S06.9X6S, S06.9X7A, S06.9X7D, S06.9X7S, S06.9X8A, S06.9X8D, S06.9X8S, S06.9X9A, S06.9X9D, S06.9X9S, S14.0XXS, S14.101S, S14.102S, S14.103S, S14.104S, S14.105S, S14.106S, S14.107S, S14.108S, S14.109S, S14.111S, S14.112S, S14.113S, S14.114S,

S14.115S, S14.116S, S14.117S, S14.118S, S14.119S, S14.121S, S14.122S, S14.123S, S14.124S, S14.125S, S14.126S, S14.127S, S14.128S, S14.129S, S14.131S, S14.132S, S14.133S, S14.134S, S14.135S, S14.136S, S14.137S, S14.138S, S14.139S, S14.141S, S14.142S, S14.143S, S14.144S, S14.145S, S14.147S, S14.148S, S14.149S, S14.151S, S14.152S, S14.153S, S14.154S, S14.155S, S14.156S, S14.157S, S14.158S, S14.159S, S14.2XXS, S14.3XXS, S14.4XXS, S14.5XXS, S14.8XXS, S14.9XXS, S24.0XXS, S24.101S, S24.102S, S24.103S, S24.104S, S24.109S, S24.111S, S24.112S, S24.113S, S24.114S, S24.119S, S24.131S, S24.132S, S24.133S, S24.134S, S24.139S, S24.141S, S24.142S, S24.144S, S24.149S, S24.151S, S24.152S, S24.153S, S24.154S, S24.159S, S24.2XXS, S24.3XXS, S24.4XXS, S24.8XXS, S24.9XXS, S34.01XS, S34.02XS, S34.101S, S34.102S, S34.103S, S34.104S, S34.105S, S34.109S, S34.111S, S34.112S, S34.113S, S34.114S, S34.115S, S34.119S, S34.121S, S34.122S, S34.123S, S34.124S, S34.125S, S34.129S, S34.131S, S34.132S, S34.139S, S34.21XS, S34.22XS, S34.3XXS, S34.4XXS, S34.5XXS, S34.6XXS, S34.8XXS, S34.9XXS, S44.00XS, S44.01XS, S44.02XS, S44.10XS, S44.12XS, S44.20XS, S44.21XS, S44.22XS, S44.30XS, S44.31XS, S44.32XS, S44.40XS, S44.41XS, S44.42XS, S44.50XS, S44.51XS, S44.52XS, S44.8X1S, S44.8X2S, S44.8X9S, S44.90XS, S44.91XS, S44.92XS, S54.00XS, S54.01XS, S54.02XS, S54.10XS, S54.11XS, S54.12XS, S54.20XS, S54.21XS, S54.22XS, S54.30XS, S54.31XS, S54.32XS, S54.8X1S, S54.8X2S, S54.8X9S, S54.90XS, S54.91XS, S54.92XS, S64.00XS, S64.01XS, S64.02XS, S64.21XS, S64.22XS, S64.30XS, S64.31XS, S64.32XS, S64.40XS, S64.490S, S64.491S, S64.492S, S64.493S, S64.494S, S64.495S, S64.496S, S64.497S, S64.498S, S64.8X1S, S64.8X2S, S64.8X9S, S64.90XS, S64.91XS, S64.92XS, S74.00XS, S74.01XS, S74.02XS, S74.10XS, S74.11XS, S74.12XS, S74.20XS, S74.21XS, S74.22XS, S74.8X1S, S74.8X2, S74.8X9S, S74.90XS, S74.91XS, S74.92XS, S84.00XS, S84.01XS, S84.02XS, S84.10XS, S84.11XS, S84.12XS, S84.20XS, S84.21XS, S84.22XS, S84.801S, S84.802S, S84.809S, S84.90XS, S84.91XS, S84.92XS, S94.00XS, S94.01XS, S94.02XS, S94.10XS, S94.11XS, S94.12XS, S94.20XS, S94.21XS, S94.22XS, S94.30XS, S94.31XS, S94.32XS, S94.8X1S, S94.8X2S, S94.8X9S, S94.90XS, S94.91XS, S94.92XS
Bipolar Disorder
F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Major Depressive Disorder
F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39
Psychotic Disorders
F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89
Alcohol Related
F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9
Substance Related
F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D, T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D,

T40.4X2A, T40.4X2D, T40.4X3A, T40.4X3D, T40.4X4A, T40.4X4D, T40.601A, T40.601D, T40.602A, T40.602D, T40.603A, T40.603D, T40.604A, T40.604D, T40.691A, T40.691D, T40.692A, T40.692D, T40.693A, T40.693D, T40.694A, T40.694D
Kidney Disease
N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0

I. Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

K. Appendix K – Whole Person Care Pilot Interaction Guidance

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Dr. David Ramirez, Chief Medical Officer, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute Amendment A09 to the Program of All-Inclusive Care for the Elderly Agreement between the California Department of Health Care Services and CalOptima regarding extension of the contract termination date to June 30, 2020

Background

Since October 2009, the CalOptima Board has taken numerous actions related to the CalOptima Program of All-Inclusive Care for the Elderly (PACE) program. On June 6, 2013, the Board authorized the execution of the PACE Agreement between the California Department of Health Care Services (DHCS) and CalOptima (DHCS PACE Agreement) as well as the agreement with the Centers for Medicare & Medicaid Services (CMS) for the operation of the CalOptima PACE site. Beginning in September 2015 and thereafter, the Board has authorized execution of various amendments to the DHCS PACE Agreement for Calendar Year (CY) payment rates and other provisions, as summarized in the Appendix to this agenda item.

The CalOptima DHCS PACE Agreement specifies, among other terms and conditions, the capitation payment rates CalOptima receives from DHCS to provide PACE participants with health care services. The current DHCS PACE Agreement expires on December 31, 2019, with the capitation rates renewed on a calendar year basis.

Discussion

On October 17, 2019, DHCS provided CalOptima with Amendment A09 for the DHCS PACE Agreement to include updates for:

- Extending the contract termination date to June 30, 2020.
- Increasing the maximum amount payable to accommodate the additional 6-months of the contract.

The DHCS PACE Agreement is being extended for only a 6-month period at this time, to provide DHCS with additional time to finalize proposed updates to the DHCS PACE Agreement template and vet with stakeholders. With the proposed amendment, all other terms and conditions in the CalOptima DHCS PACE Agreement remain the same. On June 21, 2019, DHCS released a draft version of the new DHCS PACE Agreement template for an opportunity to comment on the proposed changes. CalOptima staff submitted feedback, as did the CalPACE Association and other PACE organizations throughout the State. DHCS is currently in the review process of all the feedback and will be hosting a call with all PACE Organizations at a future date, after its review has been completed to discuss the updates that will be finalized. CalOptima

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staff will return to the Board at that time, as the new DHCS PACE Agreement template is expected to replace the existing DHCS PACE Agreement (DHCS is referring to this process as the "Contract Overhaul"), instead of adding on additional Amendments.

Fiscal Impact

The recommended action to execute Amendment A09 to the DHCS PACE Agreement increases the maximum allowed funding by $17.2 million to extend the contract termination date to June 30, 2020, under the same terms and conditions of the current agreement. The funding amount is a budgeted item, with no additional fiscal impact. Management has incorporated draft Calendar Year (CY) 2019 and forecasted CY 2020 PACE capitation rates into the CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

CalOptima's execution of Amendment A09 to the DHCS PACE Agreement is necessary for the continued operation of CalOptima PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to PACE Primary Agreements

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 5

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

Amendments to Primary Agreement with DHCS	Board Approval
A01 provided revised Upper Payment Limit (UPL) and capitation rates for Calendar Year (CY) 2013 for the period of October 1, 2013 through December 31, 2013; and UPL methodology and CY 2014 rates for the period of January 1, 2014 through December 31, 2014. Revised capitation rates for the Medi-Cal *Dual* population and *Medi-Cal only* population to have built-in adjustments for Medi-Cal program changes. Also incorporated adult expansion group into aid code table: a. Added adult expansion aid codes M1, L1, 7U under adult expansion group. b. Added aid codes 3D and M3 under Family group.	September 3, 2015
A02 provided revised UPL and capitation rates for CY 2015 for the period of January 1, 2015 through December 31, 2015. Revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population to have built-in adjustments for Medi-Cal program changes.	September 3, 2015
A03 provided revised UPL and capitation rates for CY 2016 for the period of January 1, 2016 through December 31, 2016, and applied the Managed Care Organization (MCO) Tax for the period July 1, 2016 through December 31, 2016. Beginning on January 1, 2017 and onward, the rates revert back to the non-MCO tax period rates in effect from January 1, 2016 through June 30, 2016, until the 2017 rates are developed and implemented with a future amendment to the CalOptima DHCS PACE Agreement. Incorporates a revised HIPAA Business Associate Addendum, Exhibit H, to replace the former Exhibit G, as of the Amendment effective date, which will require compliance with DHCS' revised data security standards.	May 4, 2017
Amend* contract to include revised language reflecting the Americans with Disabilities Act (ADA) for 508 compliance. *On 9/20/17, DHCS informed CalOptima this would be moved to be captured in A04.	August 3, 2017
A04 provided an extension of the contract termination date to December 31, 2018 and incorporated ADA compliance language.	December 7, 2017
Future Amendment (A05) provided draft capitation rates for CY 2017 for the period of January 1, 2017 through December 31, 2017, developed by the "Amount That Would Have Otherwise Been Paid (AWOP)", and apply the Managed Care Organization (MCO) Tax for the period January 1, 2017 through June 30, 2017.	December 7, 2017
A06 provided an extension of the contract termination date to December 31, 2019.	November 1, 2018

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Amendments to Primary Agreement with DHCS	Board Approval
A07 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2018 for the period of January 1, 2018 through December 31, 2018 and applies the Managed Care Organization (MCO) Tax for this period. First time rates for PACE developed using the Rate Development Template (RDT)/experience-based rate methodology. Incorporates additional language updates for various contract provisions, including restrictions on delegation as well as emergency preparedness.	April 4, 2019
A08 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2019 for the period of January 1, 2019 through December 31, 2019 and applies the Managed Care Organization (MCO) Tax for this period. Incorporates additional language updates for other contract provisions, including Nursing Facility Services payment rates.	September 5, 2019
A09 provided an extension of the contract termination date to June 30, 2020.	**Pending**
Amendments to Primary Agreement with CMS	**Board Approval**
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016
A02 CalOptima PACE initiated a waiver to allow Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in CalOptima PACE, which was approved by CMS on March 12, 2018 and amended *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	September 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

6. Consider Authorizing and Directing Execution of Amendment(s) to the Primary Agreement with the California Department of Health Care Services

Contact

Silver Ho, Executive Director, Compliance (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to the incorporation of language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with the California Department of Health Care Services (DHCS). Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

Amendment for the Medicaid and CHIP Managed Care Final Rule (Final Rule)

On May 6, 2016, the Centers for Medicare & Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, CMS-2390-F (Final Rule). The Final Rule contains various provisions that State Medicaid Agencies, including DHCS, were required to implement by various deadlines, beginning in July 2017.

DHCS implemented the requirements of the Final Rule by issuing of sub-regulatory guidance like All Plan Letters (APLs). Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS's contracts with Managed Care Plans (MCPs), like CalOptima. Due in part to the lengthy CMS review process, DHCS has implemented these requirements prior to their formal inclusion in MCP contracts.

DHCS compiled changes to MCP contracts that were prompted by the Final Rule's issuance and that were required to be implemented in 2017 into a single amendment, referred to as the 2017 Final Rule Amendment. In June 2017, the CalOptima Board authorized the Chair to execute the 2017 Final Rule Amendment based on a draft amendment provided to MCPs by DHCS. As a result of being under CMS review for over two years and iterative changes made by DHCS and CMS, the content of the draft 2017 Final Rule Amendment has been updated since the CalOptima Board granted signature authority in June 2017.

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Among the changes are updates to the Grievances and Appeals language to properly align with Title 42, Code of Federal Regulations (CFR), Section 438.402–424 and updates to the Medical Loss Ratio (MLR) language to ensure compliance with Title 42, CFR, Section 438.8. What follows is a brief summary of the major changes contained within the updated amendment:

	Requirement
Grievance and Appeals	Member Grievance and Appeal System: Follow grievance and appeal requirements including the use of all notice templates included in DHCS All–Plan Letter 17–006.
	Grievance Process: Members may file a grievance at any time to express dissatisfaction.
	Grievance and Appeal Log and Reporting: Submission of grievance and appeal reports in a form and manner specified by DHCS.
	Notice of Action (NOA): Formal letter informing Members of action taken and sent within regulatory timeframes. The NOA must include among other criteria, reason for the action taken and appeal rights.
	Appeal Process: Following receipt of the NOA, Members have 60 calendar days to a request for appeal, either orally or in writing. Members can file a State Fair Hearing (SFH) if the internal appeal process has been exhausted. Covered services can continue to be provided while the appeal is pending. Members can examine their case file considered during the appeals process.
	Responsibilities in Expedited Appeals: Members, Providers, or authorized representatives acting on behalf of the Member and with the Member's written consent, may file an expedited appeal either orally or in writing. Members must be provided a written notice within 72 hours from the receipt of an appeal.
	State Fair Hearings (SFHs): Members, Providers, or authorized representative may request a SFH after exhausting all-Plan level appeals. Upon resolution of an appeal, a Member has 120 calendar days to file a SFH. Expedited resolution of appeals must be completed within 72 hours.
Medical Loss Ratio (MLR)	Medical Loss Ratio (MLR): Follow MLR requirements in accordance with federal regulations.

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	MLR Reporting Year: Ratio of the numerator (Sum of incurred claims, expenditures for activities that improve health care quality and fraud prevention activities) divided by the denominator (adjusted premium revenue).
	Allocation of Expense: Inclusion of each expense under only one type of expense, unless a portion of the expense can be categorized under the definition of, or criteria for, different types of expenses.
	Credibility Adjustment: Can be added to a calculated MLR if the MLR Reporting Year is partially credible.
	Aggregation of Data by eligible member groups outlined in Final Rule amendment, or as otherwise directed by DHCS.
	MLR Reporting Requirements: Submission of an MLR Report for each MLR reporting year in a form and manner specified by DHCS.

It is important to note that these updates to the 2017 Final Rule Amendment simply formalize changes that DHCS has already implemented via sub-regulatory guidance.

On November 13, 2019, the DHCS informed Plans that CMS has concluded their review of the revised amendment. DHCS has informed MCPs that will be sending the revised amendments by November 25, 2019 and that it will request signature and return of the amendment as soon as possible. At this time, the amendment does not contain any rate changes or otherwise set any rates.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated Fiscal Year 2019-20 Operating Budget, approved by the Board on June 6, 2019. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

The contract language revisions related to the MLR is revenue neutral to CalOptima, as it does not materially change CalOptima's current MLR calculation methodology.

Rationale for Recommendation

CalOptima's execution of the 2017 Final Rule amendment to its Primary Agreement with DHCS is necessary to ensure compliance with the requirements of the Medicaid and CHIP Managed Care Final Rule and for the continued operation of CalOptima's Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Appendix summary of amendments to Primary Agreements with DHCS
2. Board Action 2017 0601_12._DHCS Primary Agreement Amendments

/s/ Michael Schrader *11/26/2019*

Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 6

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates)

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	May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS)

Contact

Nancy Huang, Interim Chief Financial Officer, (714) 246-8400
Silver Ho, Executive Director of Compliance, (714) 246-8400

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between the Department of Health Care Services (DHCS) and CalOptima related to the incorporation of language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).
2. Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to rate changes.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Amendment for Medicaid and CHIP Managed Care Final Rule (Final Rule)

In April 2016, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register the Medicaid and CHIP Managed Care Final Rule [Medicaid Managed Care (CMS-2390-F)], which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections. This Final Rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade. These regulations are sometimes referred to in aggregate as the "Mega Reg."

In the ensuing months, DHCS undertook an effort to plan to develop guidance to incorporate the requirements of the Final Rule, and it also began to draft amendments to its contracts with Managed Care Plans (MCPs), including CalOptima.

This Amendment to CalOptima's Primary Agreement with DHCS provides language changes for the addition of Final Rule requirements. The specific changes in the Amendment are summarized in the Discussion section below.

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Implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates additional amendments to the contract to address the following provisions of the Final Rule:

- External Quality Review;
- Managed Care Quality Strategy;
- Network Adequacy and Validation;
- Provider Screening and Enrollment;
- Annual Network Certification; and
- Quality Rating System for MCPs.

Amendment for Rate Changes

On April 3, 2017, DHCS submitted an amendment to CMS for approval that will revise CalOptima's Optional Expansion capitation rates for the period of January 1, 2015 to June 30, 2015. These rates have been revised to include the impact of the Hospital Quality Assurance Fee (QAF) required by Senate Bill (SB) 239.

Discussion

Amendment for Medicaid and CHIP Managed Care Final Rule (Final Rule)

On April 18, 2017, DHCS provided Managed Care Plans (MCPs), including CalOptima, with a copy of an amendment that it submitted to CMS for approval that is intended to bring its contracts with MCPs into alignment with the requirements set forth in the Final Rule. Once CMS concludes its review of DHCS's proposed amendment, DHCS will incorporate any required changes to the document and provide the amendment to CalOptima for prompt execution and return. If the amendment is not consistent with Staff's understanding as presented in this document or if it includes significant unexpected language or rate changes, Staff will return to the Board of Directors for further consideration.

At this time, the amendment does not include any rate changes or otherwise set any rates. However, the language contained in the amendment addresses a broad array of changes that DHCS is implementing to bring MCP contracts into compliance with the Final Rule. What follows is a brief summary of a number of the major changes contained within the amendment:

Requirement[1]	
Credentialing	Credentialing efforts must comply with DHCS guidance, including All Plan Letter (APL) 16-012: Provider Credentialing and Recredentialing, which incorporates a uniform credentialing and recredentialing policy for acute, primary, specialist, behavioral, substance use disorders, and long-term services and supports (LTSS) providers, as well as provider enrollment screening requirements.

[1] DHCS Planned Guidance for MCPs – Managed Care Final Rule Implementation Requirements

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Requirement[1]	
Grievances and Appeals	Members must exhaust all plan-level appeals prior to filing for a State Hearing. Members have 60 calendar days to file an appeal upon receipt of a Notice of Adverse Benefit Determination. Upon resolution of an appeal, a member has 120 calendar days to file a State Hearing. Expedited resolution of appeals must be completed within 72 hours.
Access and Cultural Consideration	Consider gender identity as a component of culturally competent care and may not discriminate on the grounds of gender identity.
Medicare Coordination	Participate in a Coordination of Benefits Agreement (COBA) between DHCS and the Medicare program through CMS, and agree to participate in Medicare's automated claims crossover process for Full Benefit Dual Eligible Dual-Eligible Beneficiary Members.
Drug Utilization Review (DUR)	Operate a DUR program that complies with the requirements of the Final Rule, including participating in the State's DUR Board, conducting a retrospective DUR and submit an annual report to DHCS of MCP DUR activities.
Formulary Requirements	Include in the Formulary the covered medications (generic and brand), on what tier the medication is, and post the Formulary in a machine readable file on the CalOptima website.
Medical Loss Ratio Requirements	Plans must calculate and report a Medical Loss Ratio (MLR) in a form and manner specified by DHCS.
Care Coordination	Make a best effort to screen all new incoming members within 90 calendar days of enrollment using the Health Information Form (HIF) / Member Evaluation Tool (MET).
Subcontracting and Delegation Requirements	Meet the subcontracting and delegation requirements, including requirements related to the content of written agreements with subcontractors, review of subcontractors' ownership and control disclosures, DHCS' expanded rights related to the audit and inspection of subcontractors, the monitoring of subcontracted and delegated functions, the monitoring of subcontractor data reporting, the requirements for subcontractors to implement and maintain procedures designed to detect and prevent Fraud, Waste, and Abuse, the requirement for subcontractors to adopt a compliance program, and the monitoring of subcontractor care coordination requirements.

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Requirement[1]	
Program Integrity	Data Certification Certify all data, information, and documentation submitted to DHCS is accurate, complete, and truthful to the MCP's best information, knowledge, and belief, in a form and manner specified by DHCS. Treatment of Recoveries Create an internal retention and documentation process for recovery of all overpayments and review quarterly for accuracy. Report annually to DHCS on the recoveries of overpayments through the rate setting process. CalOptima must report overpayments to network providers in excess of $25 million to DHCS.
Network Composition	Meet the requirement to contract with Rural Health Clinics, Federally Qualified Health Clinics, and Freestanding Birthing Centers, as applicable.
Record Retention	Retain records for a period of ten years, and impose this requirement on Subcontractors.
Terminology Changes	Update terms and definitions used in the contract.
Quality Improvement	Implement a Quality Assessment and Performance Improvement Program, and collect and submit performance measurement data.

In preparation for the additional requirements related to the Final Rule, CalOptima's Regulatory Affairs & Compliance Department provided CalOptima staff with detailed analyses of the initial related CMS Notice of Proposed Rulemaking (NPRM), the draft Final Rule, the Final Rule, guidance provided by DHCS, and revisions to the contract to ensure compliance with the Final Rule and related contract requirements. Staff is in the process of evaluating these requirements as well as the resources commitment that will necessary to achieve full compliance.
DHCS has further advised that it will require MCPs to submit deliverables related to the amendment in advance of the July 1, 2017 effective date of the contract. DHCS's requested deliverables include Policies & Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. Some of these deliverables will be due from CalOptima to DHCS prior to July 1, 2017. To the extent that CalOptima staff must provide information to DHCS to meet the deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Amendment for Rate Changes
DHCS's proposed amendment seeks to incorporate rate changes related to SB 239 to the Optional Expansion capitation rates for the period of January 1, 2015 to June 30, 2015. The revised optional expansion capitation rates for January 2015 to June 2015 relate to the QAF, and were sent to CalOptima in April 2017. SB 239 imposes a QAF from January 1, 2014 to December 31, 2016, and authorizes the framework for the existing QAF built into CalOptima's rates, which have been

approved numerous times by the CalOptima Board of Directors, including most recently in December 2016. This amendment revises the Optional Expansion rates for the QAF for the period of January 1, 2015 to June 30, 2015.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule into the Primary Agreement is included in the CalOptima FY 2017-18 Operating Budget pending Board approval. If the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

The revised Optional Expansion capitation rates for the period of January 1, 2015, through June 30, 2015 under SB 239 results in an average per member per month increase of $82.66. By statute, CalOptima will pass through to participating hospitals the full amount of supplemental hospital funds it receives from DHCS.

Rationale for Recommendation

CalOptima's execution of the Final Rule amendment to its Primary Agreement with DHCS is necessary to ensure compliance with the requirements of the Medicaid and CHIP Managed Care Final Rule and for the continued operation of CalOptima's Medi-Cal program. Additionally, CalOptima's FY 2014-15 Operating Budget was based on the anticipated rates from DHCS. Therefore, execution of the rate amendment will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/25/2017*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 12

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015

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A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 . adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 Adjusts the 2013-2014 capitation rates for the Optional Expansion and Senate Bill (SB) 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into the primary agreement	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for rate period of July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015.	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided to the Secondary Agreement.	December 4, 2014

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A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

7. Consider Authorizing Further Actions Related to the California Department of Health Care Services Medi-Cal Provider Enrollment Requirements

Contact

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

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to issue Letters of Agreement with non-Medi-Cal enrolled specialist/Behavioral Health providers identified by the Chief Medical Officer through December 31, 2020, as required for access to services or continuity of care purposes.

Background

In April 2016, the Centers for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The revised regulation includes requirements that providers in Managed Care Plans (MCPs), including CalOptima, be subject to the same provider enrollment and screening requirements as providers who participate in Medicaid state fee-for-service programs. The enrollment and screening requirements are in addition to credentialing requirements and meant to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification. Although the new state-mandated enrollment and screening requirements were effective January 1, 2018, DHCS guidance clarified that non-Medi-Cal enrolled providers contracted with MCPs prior to that date had until December 31, 2018, to complete the process. On June 12, 2019, DHCS issued All Plan Letter (APL) 19-004, which specified MCPs' responsibilities related to the screening and enrollment of all Medi-Cal network providers.

To date, the Board has approved two extensions to allow CalOptima's non-Medi-Cal enrolled providers to maintain their CalOptima contracts while completing the enrollment process. On November 1, 2018, the Board granted the first extension, allowing providers to remain contracted with CalOptima until June 30, 2019, provided that they had submitted their Medi-Cal enrollment applications to DHCS prior to January 1, 2019. On May 2, 2019, the Board authorized a second extension, allowing providers to remain contracted with CalOptima until December 31, 2019 to allow additional time for completion of the processing of their Medi-Cal enrollment applications, again, provided that they had submitted their Medi-Cal enrollment applications to DHCS prior to January 1, 2019.

As of November 2019, more than 10,600 CalOptima-contracted providers are Medi-Cal enrolled, with more than 2,000 providers having initiated the enrollment process in response to CalOptima's extensive communication and outreach efforts since April 2018. At this time, our records indicate that just 249 specialists and 25 primary care providers (PCPs) contracted with CalOptima remain non-enrolled with Medi-Cal. Per the May 2, 2019, Board action, contracts for non-Medi-Cal enrolled providers are to be terminated effective December 31, 2019.

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Discussion

With the deadline for the final extension approaching, staff is prioritizing continuity of care for Medi-Cal members who will be affected by provider terminations as of January 1, 2020. Members impacted by the 25 PCP terminations have been notified that they may select a new PCP and if they do not choose, they will be automatically reassigned to a Medi-Cal enrolled PCP. Members impacted by specialist terminations will be addressed through continuity of care and the use of Letters of Agreement (LOA).

Per CalOptima policy EE.1141, the LOA process is available to enter into a contract directly with an out of network provider, in instances where medically necessary, covered services are required. In this circumstance, staff will seek an exception to CalOptima's traditional use of LOAs, which requires the member or the provider to individually pursue the LOA.

While LOAs will be provided upon member request for all non-BH specialties, staff has determined that a proactive approach is best suited for members receiving BH services. Of the 249 specialists pending Medi-Cal enrollment, 153 are Behavioral Health (BH) providers who serve approximately 6,000 CalOptima members. The impact of terminating these providers at the same time may, in some cases, lead to challenges in accessing services as members are redirected to contracted providers who are enrolled in the Medi-Cal program with DHCS.

To ease the transition for BH members and alleviate potential disruption of services, staff seeks authority to proactively pursue LOAs with BH providers who are non-enrolled as of the December 31, 2019 deadline. Per CalOptima policy GG.1304, members have a right to request continuity of care. However, due to the high volume of members potentially impacted, this proactive approach is intended to mitigate that burden from the members while their treatment is finalized, or they are transitioned to enrolled providers. BH staff is set to have the transitions completed in a year or less.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget, approved by the Board on June 6, 2019, includes forecasted professional medical expenses. The recommended action to authorize LOAs with non-Medi-Cal enrolled specialist providers is not anticipated to have an additional fiscal impact, assuming the State takes no actions related to recovery of payments made to non-enrolled providers as overpayments and does not find CalOptima to be non-compliant such that it issues sanctions or take related actions.

Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, related to the LOAs with certain specialist providers in the FY2020-21 operating budget.

Rationale for Recommendation

Continuation of members' BH services with their current providers via LOA ensures CalOptima minimizes the member impact during transitions to Medi-Cal-enrolled providers. This will reduce disruption of care and enhance the overall member experience.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. DHCS All Plan Letter 19-004
2. CalOptima Board Action dated November 1, 2018, Consider Authorizing Actions Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services
3. CalOptima Board Action dated May 2, 2019, Consider Authorizing Further Action Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services
4. CalOptima Policy & Procedure GG.1304
5. CalOptima Policy & Procedure EE.1141

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: **June 12, 2019**

ALL PLAN LETTER 19-004
SUPERSEDES ALL PLAN 17-019

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F, dated May 6, 2016.[1] Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 of the Code of Federal Regulations (CFR), Section 438.214.[2] The screening and enrollment responsibilities are located in Part 1 and the credentialing and recredentialing responsibilities are located in Part 2 of this APL. This APL supersedes APL 17-019.[3]

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act.[4] The intent of Title 42 of the CFR, Part 455, Subparts B and E was to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.[5]

The Final Rule extended the provider screening and enrollment requirements of Title 42 of the CFR, Part 455, Subparts B and E to MCP network providers. These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

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[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[2] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=ed7b5cfe19321ccc382dbc8dbfef17cb&mc=true&node=pt42.4.438&rgn=div5
[3] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] 42 CFR, Part 455 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

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MCPs are required to maintain contracts with their network providers (Network Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal program. Title 42 of the CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, aligning with the FFS enrollment requirements described in Title 42 of the CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards. The Medi-Cal managed care program and MCPs must comply with statewide Medi-Cal FFS enrollment standards and federal enrollment standards when verifying enrollment of providers through a state-level enrollment pathway or developing a provider enrollment pathway.[6] The 21st Century Cures Act (Cures Act) required managed care network provider enrollment to be implemented by January 1, 2018.[7]

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[8] Credentialing is defined as the recognition of professional or technical competence.[9] The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

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[6] Welfare and Institutions Code (WIC), Sections 14043 through 14045. WIC, Sections 14043 through 14045 are available at: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=1.3.

[7] Title 42 of the United States Code (USC), Section 1396u-2(d)(6)(A). The USC is searchable at: http://uscode.house.gov/

[8] MCP Contract, Exhibit A, Attachment 4, Credentialing and Recredentialing. MCP contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

[9] MCP Contract, Exhibit A, Attachment 1, Definitions.

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POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCP network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program.[10, 11] State-level enrollment pathways are available either through the Department of Health Care Services' (DHCS) Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.[12] MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or MCPs may direct their network providers to enroll through a state-level enrollment pathway. DHCS' PED is the primary developer of state-level enrollment pathways for FFS providers. If an MCP chooses to enroll a provider type into their network that does not have an enrollment pathway through PED, DHCS will recognize all other state-level enrollment pathways.

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers.[13] MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through a state-level enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP cannot participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through a state-level enrollment pathway. For providers who are

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[10] "Network provider" is defined in 42 CFR, Section 438.2, available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=1b74655ecc02b0de9edb16df3de9284e&ty=HTML&h=L&mc=true&r=SECTION&n=se40.32.438_12

[11] More information on network provider status is available in APL19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status.

[12] For a complete list of state-level enrollment pathways, refer to the resource listing on the PED Frequently Asked Questions (FAQ) webpage, available at: https://www.dhcs.ca.gov/provgovpart/Pages/PEDFrequentlyAskedQuestions.aspx

[13] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

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typically required to enroll but are restricted due to a moratorium, MCPs must develop their own enrollment pathway if the MCP chooses to include them in their network.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis. Additionally, pursuant to the July 24, 2018, CMS Medicaid Provider Enrollment Compendium (MPEC), MCPs will no longer be required to enroll providers that do not have a state-level enrollment pathway.[14] Additionally, DHCS will only process provider applications that have a state-level enrollment pathway established by DHCS' PED[15]; therefore, applications submitted to DHCS from providers that do not have a state-level enrollment pathway through PED will be denied. MCPs who choose to enroll these providers must do so through their own established enrollment process, through the recognized enrollment process developed by another MCP, or, if applicable, through a state-level enrollment pathway established by another state department.

MCP Enrollment Processes
If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:
A. MCP Provider Application and Application Fee
MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[16] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and completeness. MCPs must ensure that all information specified in Title 22 of the California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments of the application package, are received.[17] As part of the application process, the MCP must obtain the provider's consent to allow DHCS and the MCP to share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.

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[14] The MPEC is available at: https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf
[15] More information on PED's enrollment process and pathways is available at: https://www.dhcs.ca.gov/provgovpart/pages/pave.aspx
[16] Application packages by provider type can be found at the following: https://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types, see 22 CCR, Sections 51000 – 51000.26 and 51051.
[17] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index

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MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[18] Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. Medi-Cal Provider Agreement and Network Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state as a condition of participating in the Medi-Cal program.[19, 20] As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the Medi-Cal Provider Agreement (DHCS Form 6208).[21] This provider agreement is separate and distinct from the Network Provider Agreement (see below). MCPs must maintain the original signed Medi-Cal Provider Agreement for each provider. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and location that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Network Provider Agreement) is separate and distinct from the Medi-Cal Provider Agreement. Both the Medi-Cal Provider Agreement and the Network Provider Agreement are required for MCP network providers. The Medi-Cal Provider Agreement does not expand or alter the MCP's existing rights or obligations relating to its Network Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42 of the CFR, Sections 455.104, 455.105, and 455.106, and Title 22 of the CCR, Section 51000.35. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information described in Title 42 of the CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42 of the CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal program. These disclosures must be provided when:

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[18] For more information on DHCS' current application fee, see the "Latest News" section of the PED homepage, available at: https://www.dhcs.ca.gov/provgovpart/pages/ped.aspx

[19] Social Security Act (SSA), Section 1902(a)(27). SSA, Section 1902 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

[20] WIC, Section 14043.1(c).

[21] The Medi-Cal Provider Agreement (DHCS Form 6208) and other relevant forms related to provider agreement requirements are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

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- A prospective provider submits the provider enrollment application.
- A provider executes the Medi-Cal Provider Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[22]

Additionally, MCPs must comply with the requirements contained in Title 22 of the CCR, Section 51000.35. MCPs are not required to utilize the DHCS disclosure forms (DHCS Forms 6207 and 6216); however, MCPs must collect all information and documentation required by Title 22 of the CCR, Section 51000.35.

D. Limited, Moderate, and High Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as limited, moderate, or high. If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening and for MCPs to stratify their network providers by risk level are set forth in Attachment A of this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs must not enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements;

[22] 42 CFR, Section 455.105(b)

- Hold a license certified for practice in the state and has no limitations from other states; and
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers

- Screening requirements of limited-risk providers; and
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers; and
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

Providers are categorized as high-risk if that provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.[23, 24]

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers – Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a 5%

[23] 42 CFR, Section 455.450(e)(2)
[24] WIC, Section 14043.38(b)(4)

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or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[25] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. MCPs must direct providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website.[26] MCPs must ensure providers include the correct agency information on the Live Scan form when submitting their application to the California DOJ so their application is processed correctly. The agency-specific information must be included in the appropriate fields as detailed below:

Applicant Submission

Field	Entry
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	Entry
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or P.O. Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

[25] WIC, Section 14043.38(c)
[26] The Live Scan form is available on Forms for Applicant Agencies webpage on the DOJ website, available at: https://oag.ca.gov/fingerprints/forms.

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When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider shall deliver the completed Live Scan form to the California DOJ. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of the criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22 of the CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. MCPs must conduct post-enrollment site visits for medium-risk network providers at least every five years, and their high-risk network providers every three years or as necessary. Post-enrollment onsite visits verify that the information submitted to the MCP and DHCS is accurate, and to determine if providers are in compliance with state and federal enrollment requirements. In addition, all providers enrolled in the Medi-Cal program, including providers enrolled through MCPs, are subject to unannounced onsite inspections at all provider locations.[27]

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[27] 42 CFR, Section 455.432

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G. Federal and State Database Checks

During the provider enrollment/reenrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:[28]

- Social Security Administration's Death Master File.[29]
- National Plan and Provider Enumeration System (NPPES).[30]
- List of Excluded Individuals/Entities (LEIE).[31]
- System for Award Management (SAM).[32]
- CMS' Medicare Exclusion Database (MED).[33]
- DHCS' Suspended and Ineligible Provider List.[34]
- Restricted Provider Database (RPD).[35]

In addition to checking all the databases upon a provider's enrollment/reenrollment, MCPs must also review the SAM, LEIE, and RPD databases on a monthly basis. All databases must be reviewed upon a provider's enrollment/reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the MCP's provider network.

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal managed care program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment that may impact the provider's eligibility to participate in the Medi-Cal program, or a provider refuses to submit to the required screening activities, the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal program.[36]

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[28] 42 CFR, Section 455.436
[29] Information on requesting access to the Social Security Administration's Death Master File is available at: https://www.ssa.gov/dataexchange/request_dmf.html
[30] NPPES is available at: https://nppes.cms.hhs.gov
[31] LEIE is available at: https://oig.hhs.gov/exclusions/exclusions_list.asp
[32] SAM is available at: https://www.sam.gov/SAM/
[33] An overview of MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html. The MED database is the source that is used to populate the LEIE list. MCPs can use the LEIE if they are not able to access MED.
[34] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[35] The Restricted Provider Database is available at: https://eportal.dhcs.ca.gov/dhcs/ai-rp. For information on gaining access to the database, refer to the FAQ included with this APL.
[36] 42 CFR, Section 455.416

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If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[37]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[38]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement in Attachment B of this APL, which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment B. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through DHCS' Medi-Cal FFS provider enrollment process.

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[37] Provider enrollment information can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx
[38] 42 CFR, Section 455.422

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- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment
To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their network providers at least every five years.[39] MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[40] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process.[41]

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

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[39] 42 CFR, Section 455.414
[40] 42 CFR, Section 438.3(u)
[41] 42 CFR, Section 438.602(b)(2)

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Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements
MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing
MCPs are required to verify the credentials of their network providers, and to verify the following items, as required for the particular provider type, through a primary source,[42] as applicable:[43]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.

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[42] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[43] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.

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- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[44]
- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the MCP's provider network.
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

MCPs are required to credential all contracted providers that render services to assigned members, whether the providers have a state-level FFS enrollment pathway or not, in accordance with state and federal law.

Attestations

For all network providers types who deliver Medi-Cal covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[45]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities all serious quality deficiencies that result in the suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including

[44] National Practitioner Data Bank is available at: https://www.npdb.hrsa.gov/
[45] For more information, see Policy Letter (PL) 02-003, or any future iterations of this PL. PLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx

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reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites.[46] MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization. The MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. However, MCPs retain overall responsibility for ensuring that credentialing requirements are met.

[46] For more information, see PL 14-004, and any future iterations of this PL.

Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including applicable APLs, PLs and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Attachments

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Attachment A
Provider Types and Categories of Risk[47]

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or the NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or the NASDAQ is considered "limited" risk
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered "limited" risk
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities
- Non-public, non-government owned or affiliated ambulance services suppliers
  - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered "limited" risk.

(3) High Risk Provider Types. Characteristics and provider types:

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[47] The CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations is available at: https://www.govinfo.gov/content/pkg/FR-2011-02-02/pdf/2011-1686.pdf

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- Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS
- Providers prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months
- Diabetes Prevention Program (DPP) providers

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Attachment B
Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that managed care providers that have a state-level FFS enrollment pathway must enroll in the Medi-Cal program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal program. Providers may enroll through either (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements: (1) the Network Provider Agreement and (2) the Medi-Cal Provider Agreement. The Network Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The Medi-Cal Provider Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. **Enrollment through an MCP.** The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

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application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.
- Providers will not have the right to appeal an MCP's decision to cease the enrollment process
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' PED for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS. The following provides information on DHCS' enrollment process:

- DHCS' Provider Enrollment page and the Provider Enrollment information on DHCS' website will be updated to reflect that PED is no longer accepting paper applications for provider types supported in the Provider Application and Validation for Enrollment (PAVE) portal. There will be links per provider type that will guide applicants to PAVE. For those provider not yet fully migrated into PAVE, the provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program until such time that the application is migrated into PAVE processing.[48]
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

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[48] For more information, see the "Application Packages by Provider Type" webpage on the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Actions Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services

Contact

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

Recommended Actions

Authorize the following actions related to the requirement that all contracted providers be enrolled in the Medi-Cal program through the Department of Health Care Services (DHCS) by January 1, 2019:

1. Authorize CalOptima to continue to contract with non-Medi-Cal enrolled providers through June 30, 2019, subject to CalOptima's receipt of proof that each such provider's application to the State to become enrolled in the Medi-Cal program was submitted to the DHCS prior to January 1, 2019; and
2. Authorize Letters of Agreement (LOA) with non-Medi-Cal enrolled specialist providers identified by the Chief Medical Officer through December 31, 2019 as required for access to services or continuity of care.

Background

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The revised regulation included requirements that providers in Managed Care Plans (MCPs) including CalOptima be subject to the same provider enrollment and screening requirements as providers who participate in Medicaid State fee-for-service programs. Provider enrollment and screening is in addition to credentialing requirements and is meant to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

On November 14, 2017, DHCS issued All Plan Letter (APL) 17-019, which specified MCP's responsibilities related to the screening and enrollment of all Medi-Cal network providers.

The contract between DHCS and CalOptima effective January 1, 2009, discontinued the requirement that providers be eligible for participation in the Medi-Cal Program. However, on October 7, 2010, the CalOptima Board of Directors approved the continuation of a policy which requires that providers furnishing services to CalOptima Medi-Cal members be enrolled with the State of California's Medi-Cal Program when an enrollment path with the State is available for the provider. In recognition that not all providers eligible to enroll with Medi-Cal would enroll, the Board also approved a policy allowing the Chief Medical Officer, or delegated providers in conjunction with the Chief Medical Officer, to make exceptions to this policy to satisfy access and continuity of care requirements in CalOptima's contract with DHCS.

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Although the new state mandated enrollment and screening requirements were effective January 1, 2018, DHCS guidance clarified that non-enrolled providers contracted with the MCPs prior to this date, have until December 31, 2018 to complete the process. Presumably, providers not enrolled by his date are to be terminated as a MCP participating provider for Medi-Cal services. Staff continues to review provider data to determine the number of non-enrolled providers and the potential impact to the members who are in their care should these providers no longer be available in the future due to their non-enrolled status.

DHCS specifies that provider screening and enrollment can be accomplished in two ways. MCPs may direct providers to the Medi-Cal enrollment division of DHCS for screening and enrollment, or MCPs may develop and implement an internal screening and enrollment process that meets the requirements of the APL. Due to the numerous additional requirements associated with the enrollment and screening process and the expertise required to fulfill these requirements, CalOptima staff believes it is more appropriate to continue to depend on the State's process to assure providers are properly vetted for Medi-Cal participation rather than to develop a duplicative process that would, in any case, lack the breadth of potentially relevant information available to the State, but not necessarily available to CalOptima.

Staff continues to conduct extensive outreach efforts to encourage non-enrolled providers to seek enrollment in the Medi-Cal program and continued participation with CalOptima. The outreach efforts have been successful, and Staff has identified the addition of over 900 previously non-enrolled providers since April 2018.

However, because the State's Medi-Cal enrollment process can take up to 180 days to complete, it is unlikely that all of the approximately 1,200 CalOptima providers not currently enrolled will complete this process by the end of the calendar year. Staff has gathered information on non-enrolled providers currently serving CalOptima Medi-Cal beneficiaries, identifying the number, specialty and potential member impact of terminating provider contracts. In the event that the existing contracts of all 1,200 currently non-enrolled CalOptima Medi-Cal providers were terminated, the results would be significant, affecting over 26,0000 Members' PCP assignments and more than 10,000 Members who access specialty care. To mitigate this potential disruption to the provider network and assure member's continued access to care, Staff is requesting Board approval of the recommended actions.

Discussion

Staff recommends that providers who are not currently enrolled with Medi-Cal but can provide proof that their Medi-Cal provider enrollment application and all required information has been submitted to the State prior to January 1, 2019, continue as contracted CalOptima participating providers until such a time as DHCS renders a decision on that provider's Medi-Cal enrollment application, potentially through June 30, 2019. As noted above, the Medi-Cal enrollment process with the state may take up to 180 days. This is a concern shared by many health plans state wide, with many opting for a similar approach of attempting to minimize member care disruption while the state works through the backlog of provider Medi-Cal enrollment applications, while also working to comply with the prescribed timelines.

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While the proposed approach of allowing additional time for the Medi-Cal enrollment process to be completed without reassigning Members from Providers with pending applications to those who have completed the DHCS Medi-Cal provider enrollment process potentially places CalOptima at risk for payment and for DHCS audit findings of CalOptima's non-compliance with the terms of the DHCS-CalOptima contract, as indicated, our understanding is that this is an approach being followed by numerous other plans to allow time for DHCS to work through the backlog of Medi-Cal provider enrollment applications.

Under the proposed approach, if any such provider is still not Medi-Cal enrolled by June 30, 2019, their contract with CalOptima will be not be extended thereafter. In addition, all non-enrolled PCPs will have their panels closed to new members until their Medi-Cal enrollment is complete. Should the provider still be in the enrollment process by June 30, 2019 (i.e., application submitted to the state on or before December 31, 2018, but state review process not having been finalized as of June 30, 2018), Staff will consider returning to the Board with further recommendations. This scenario would only be a possibility in the event that there were further delays in the state's enrollment process.

Apart from those providers who have indicated that they plan to submit their Medi-Cal enrollment applications on or before December 31, 2018, staff has identified members in care with non-enrolled providers who are required for access and may choose not to apply to enroll in Medi-Cal. The impact of terminating these providers could create barriers to access sensitive or highly specialized services and/or redirecting members to other providers may be disruptive to member care. Staff proposes to proactively pursue LOAs with these terminated providers to allow for uninterrupted access by Members for whom there is not a suitable alternative contracted provider at this time. DHCS has advised MCPs that MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis. COC requests would be processed in accordance with CalOptima's DHCS-approved policies on the topic. Staff plans to proactively identify members in care with non-enrolled providers required for access; subject to Board approval, Staff will enter into LOAs for members currently in care with these providers to enable members and providers to continue uninterrupted care as longer-term efforts are undertaken to ensure that, member care is being provided by Medi-Cal enrolled providers.

As indicated, implementation of these actions without DHCS approval could place potentially place CalOptima and other plans throughout the state at risk for any payments made to such non-Medi-Cal enrolled providers and may also result in audit findings from the State, the consequences of which may be corrective action plan(s) and/or sanctions. However, with a focus on ensuring member access to crucial healthcare services, staff recommends proceeding with the proposed approach.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget, approved by the Board on June 7, 2018, includes forecasted professional medical expenses. The recommended actions to continue contracts with certain non-Medi-Cal enrolled providers through June 30, 2019, and issue to certain specialist providers are not projected to result in a material change to the budgeted medical expenses. Therefore, the recommended actions are budgeted items with no additional fiscal impact assuming the State takes

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no actions related to payments made to non-enrolled providers and does not find CalOptima to be non-compliant and issue sanctions or take other related action(s).

Management will include revenue and expenses for the period of July 1, 2019, through December 31, 2019, related to the LOAs with certain specialist providers in future operating budgets.

Rationale for Recommendation

Continued access to providers in the process of being enrolled in Medi-Cal and services identified as crucial to avoid barriers in access to care will allow members to receive uninterrupted care notwithstanding the DHCS requirements that all providers enroll in the Medi-Cal program effective January 1, 2019.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS issued All Plan Letter (APL) 17-019
2. CalOptima Board Action dated October 7, 2010, Authorize Revisions to Credentialing and Provider Participation Requirements in CalOptima's Medi-Cal Program

/s/ Michael Schrader — **Authorized Signature**

10/24/2018 — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: November 14, 2017

ALL PLAN LETTER 17-019
SUPERSEDES ALL PLAN LETTER 16-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F,[1] dated May 6, 2016. Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 Code of Federal Regulations (CFR), Section 438.214.[2] This APL supersedes APL 16-012.[3] The screening and enrollment responsibilities are located in Part: 1 and the credentialing and recredentialing responsibilities are located in Part: 2 of this APL.

All MCP network providers must enroll in the Medi-Cal Program. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through the Department of Health Care Services (DHCS). MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018.

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC[4] to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act. The intent of Title 42 CFR, Part 455, Subparts B and E[5] was to reduce the

[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] Title 42 CFR Section 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1214
[3] APL 16-012 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-012.pdf
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] Title 42 CFR, Part 455, Subparts B and E are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

In May 2016, CMS issued rulemaking CMS-2390-F, which extended the provider screening and enrollment requirements of 42 CFR, Part 455, Subparts B and E to MCP contracted providers (Title 42 CFR, Section 438.602(b)). These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

MCPs are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal Program. Title 42 CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers[6] as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards that the Medi-Cal managed care program and MCPs must now implement.[7] Although the implementation date for Title 42 CFR Section 438.602(b) is not scheduled until July 1, 2018, Section 5005(b)(2) of the 21st Century Cures Act (Cures Act),[8] requires managed care network provider enrollment to be implemented by January 1, 2018.

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[9] Credentialing is defined as the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

[6] Exhibit E, Attachment 1 Definitions. The MCP Boilerplate contracts can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[7] State-specific Medi-Cal FFS provider enrollment requirements are contained in Title 22, CCR, Section 51000 through 51051, and Welfare & Institutions Code, Division 9, Part 3, Chapter 7 (commencing with Section 14043).
[8] 42 USC § 1396u-2 (d)(6)(A)
[9] Exhibit A, Attachment 4, Credentialing and Recredentialing.

POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal[10] to obtain a list of currently enrolled Medi-Cal FFS providers. MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through the DHCS enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP may not also participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from, the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through DHCS.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

MCP Enrollment Processes

If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[11] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and

[10] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

[11] Applications packages by provider type can be found at the following: http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types see Title 22 CCR 51000 – 51000.26 and 51051.

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completeness. MCPs must ensure that all information specified in Title 22, California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments to the application package have been received. The MCP must obtain the provider's consent in order for DHCS and the MCP to share information relating to the provider's application and eligibility, including but not limited to issues related to program integrity.

MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[12] The application fee for calendar year 2017 is $560. Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. DHCS Provider Enrollment Agreement and Plan Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state (DHCS Provider Enrollment Agreement) as a condition of participating in the Medi-Cal Program pursuant to Section 1902(a)(27) of the Social Security Act and Section 14043.1 of the Welfare & Institutions Code. As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the DHCS Provider Enrollment Agreement. This provider agreement is separate and distinct from the Plan Provider Agreement (see below). MCPs must maintain the original signed DHCS Provider Enrollment Agreement for each provider and must submit a copy to DHCS, CMS, and other appropriate agencies upon request. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and place that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Plan Provider Agreement) is separate and distinct from the DHCS Provider Enrollment Agreement. Both the DHCS Provider Enrollment Agreement and the Plan Provider Agreement are required for MCP network providers. The DHCS Provider Enrollment Agreement does not expand or alter the MCP's existing rights or obligations relating to its Plan Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42, CFR, Sections 455.104, 455.105, and 455.106, and Title 22, CCR, Section 51000.35. Providers who are unincorporated sole-proprietors are not required to

[12] Application Fee information is available at: http://www.dhcs.ca.gov/provgovpart/Pages/AppFeeChange2017.aspx

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disclose the ownership or control information described in Title 42, CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42, CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal Program. These disclosures must be provided when:

- A prospective provider submits the provider enrollment application.
- A provider executes the DHCS Provider Enrollment Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[13]

Additionally, MCPs must comply with the requirements contained in Title 22, CCR, Section 51000.35, Disclosure Requirements. MCPs are not required to utilize the DHCS disclosure forms (DHCS 6207 and 6216[14]); however, MCPs must collect all information and documentation required by Title 22, CCR, Section 51000.35.

D. "Limited," "Moderate," "High" Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as "limited," "moderate," or "high." If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening requirements and for MCPs to stratify their network providers by risk level are set forth in Attachment 1 to this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs are

[13] 42 CFR 455.105(b)
[14] DHCS Forms 6207 and 6216 are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

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not able to enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements.
- Hold a license certified for practice in the state and has no limitations from other states.
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers:

- Screening requirements of limited-risk providers.
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers.
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers - Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a

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5% or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[15] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. DHCS will make a pre-filled Live Scan form available to all MCPs to distribute to providers. When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22, CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. In addition, all providers enrolled in the Medi-Cal Program, including providers enrolled through MCPs,[16] are subject to unannounced onsite inspections at all provider locations.

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal Program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[15] Welfare and Institutions Code 14043.38(c)(2)
[16] 42 CFR 455.432

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G. Federal and State Database Checks

During the provider enrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File.[17]
- National Plan and Provider Enumeration System (NPPES).[18]
- List of Excluded Individuals/Entities (LEIE).[19]
- System for Award Management (SAM).[20]
- CMS' Medicare Exclusion Database (MED).[21]
- DHCS' Suspended and Ineligible Provider List.[22]

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal Managed Care Program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment, that may impact the provider's eligibility to participate in the Medi-Cal Program, or a provider refuses to submit to the required screening activities,[23] the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal Program.

If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[24]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[25]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and

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[17] Social Security Administration's Death Master File is available at: https://www.ssdmf.com/
[18] NPPES is available at: https://nppes.cms.hhs.gov
[19] LEIE is available at: https://oig.hhs.gov/exclusions/exclusions_list.asp
[20] SAM is available at: https://www.sam.gov
[21] MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html
[22] Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[23] 42 CFR 455.416
[24] Provider Enrollment information can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx.
[25] 42 CFR 455.422

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DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement (Attachment 2), which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment 2. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- Notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through the DHCS' Medi-Cal FFS provider enrollment process.
- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS Program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their limited-risk and medium-risk network providers at least every five years,[26] and their high-risk network providers every three years. MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

[26] 42 CFR 455.414

Data Base Checks
MCPs must review the SAM and LEIE databases on a monthly basis. All other databases must be reviewed upon a provider's reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal Programs; any provider terminated from the Medicare or Medicaid/Medi-Cal Program may not participate in the MCP's provider network.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[27] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process, in accordance with Title 42, CFR, Section 438.602(b)(2).

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements

MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing

[27] 42 CFR 438.3(u)

body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing

MCPs are required to verify the credentials of their contracted medical providers, and to verify the following items, as required for the particular provider type, through a primary source,[28] as applicable:[29]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[30]

[28] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[29] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.
[30] National Practitioner Data Bank is available at: https://www.ncsbn.org/418.htm.

- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List may not participate in the MCP's provider network.[31]
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

Attestations

For all medical service provider types who deliver Medi-Cal-covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[32]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities serious quality deficiencies that result in suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites. For detailed guidance, see Policy Letter (PL) 14-004, Site Reviews, Facility Site Review and Medical

[31] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

[32] These limited statements comply with requirements of the Americans with Disabilities Act (ADA), as discussed in the attached PL 02-03. The ADA Attachment is available at (pg. 7): http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf.

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Record Review,[33] and any subsequent revisions to this PL. MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. MCPs; however, retain overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

[33] Policy Letter 14-004 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf

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MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including applicable APLs, PLs and Dual Plan Letters. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

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Attachment 1: Provider Types and Categories of Risk[34]/Screening Requirements

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities

[34] CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations

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- Non-public, non-government owned or affiliated ambulance services suppliers
    - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.

(3) High Risk Provider Types. Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.

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Attachment 2: Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

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application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.

- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS.

- The provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2010
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Authorize Revisions to Credentialing and Provider Participation Requirements in CalOptima's Medi-Cal Program

Contact

Gertrude S. Carter, M.D., Chief Medical Officer, (714) 246-8400
Greg Buchert, M.D., MPH, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Approve policy continuing the requirement that providers furnishing services to CalOptima Medi-Cal members be enrolled in the State of California Medi-Cal Program when enrollment is available for that type of provider;
2. Approve an exception to that Policy for providers outside of Orange, Los Angeles, San Bernardino, Riverside and San Diego Counties;
3. Approve policy that the Chief Medical Officer or delegate, and delegated providers have the ability to make exceptions to the policy identified in Recommended Action No. 1 to satisfy access and continuity of care requirements in CalOptima's contract with the California Department of Health Care Services (DHCS);
4. Approve policy that providers credentialed by CalOptima or its delegated providers that furnish services, goods or supplies to Healthy Families or OneCare members are encouraged, but not required to, enroll in the State of California Medi-Cal program;
5. Eliminate the Minimum Practitioner Standards (MPS) Policy and requirement for applicable physicians to complete the MPS form prior to credentialing; and,
6. Approve changes to CalOptima's policies to reflect the changes made in this CalOptima Board Action Agenda Referral.

Background

CalOptima contracts directly with providers, or with delegated entities to arrange for providers, to render services to its members. For CalOptima's Healthy Families and OneCare programs, the providers' qualifications are evaluated by standardized credentialing processes that are consistent with NCQA standards and if deemed qualified, can provide services and bill for those services. CalOptima requires the California Department of Health Care Services (DHCS) statutory process related to authorized categories of persons and entities that provide services, goods, and supplies to Medi-Cal recipients. The State process is intended to ensure that provider practices are consistent with sound fiscal and business practices and do not result in unnecessary cost to the State Medi-Cal program and that the State/CalOptima do not have to reimburse the State or CMS for ineligible providers. The State also requires that a provider meet federal disclosure requirements including, without limitation, those related to the provider's licensure, control and ownership interests, and health care program participation status. In reviewing

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provider applications, the State has the authority to conduct unannounced visits, pre-enrollment inspections, background checks and access government resources related to convictions, pending investigations and the status of debts and penalties, if any, owed to government entities.

The State has also established enrollment moratoriums related to specific provider types throughout the State or within specific counties in order to "safeguard public funds and maintain the fiscal integrity of the Medi-Cal program." For example, the State has a moratorium on enrollment of durable medical equipment suppliers (with exceptions) that expressly includes Orange, Los Angeles, Riverside and San Bernardino Counties. Significantly, the State provider enrollment laws incorporate the State's right to summarily deny or suspend a provider's enrollment status, for example, where there are pending allegations of fraud or abuse or investigations related to same.

Prior to January 1, 2009, CalOptima's State Medi-Cal contract with the DHCS required that "each provider who delivers Covered Services to Members shall *be eligible* for participation in the Medi-Cal program and shall meet applicable requirements established under Titles XVIII and XIX of the Social services Act unless exempted from these provisions." The State's enrollment process may take as long as twelve months for a provider to receive acknowledgement of enrollment. While most providers complied with this requirement, some providers discontinued attempting to be paid for services rendered or refused to provide future services to CalOptima members.

In addition to standard credentialing requirements for all providers and the supplemental Medi-Cal enrollment procedure for providers in certain CalOptima medical delivery systems, CalOptima initiated a requirement for providers to supply additional information in order to be paid by CalOptima – the Minimum Practitioner Standards (MPS) form based on the CalOptima Board-approved policy. This policy was adopted in part to allow for a contracted COD network and to provide a basis of denying provider participation without the necessity of a formal statutorily-required hearing for providers who could not meet the standards. All questions of this seven question form request identical information that is included on credentialing applications. Eliminating the MPS form may result in the CalOptima having to file a notice to the Medical Board of California (an "805" report) for COD or Hospital Risk providers in the Medi-Cal program for which CalOptima takes certain actions based on a medical or disciplinary cause or reason. This requirement already exists for PHCs, HMOs, and SRGs in the CalOptima Healthy Families and OneCare programs.

CalOptima entered into a new State Medi-Cal contract with DHCS on January 1, 2009. The contract *no longer* includes language requiring "each provider who delivers Covered Services to Members shall be eligible for participation in the Medi-Cal program and shall meet applicable requirements established under Titles XVIII and XIX of the Social Services Act unless exempted from these provisions." The new 2009 State Medi-Cal contract also includes the following language: "Nothing in this provision shall be construed to require that subcontracting providers be enrolled as a Medi-Cal provider." The new State Medi-Cal contract does incorporate a

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Prepaid Health Plan statute which expressly prohibits contracts between DHCS and PHPs "unless the providers and the facilities of the prepaid health plan meet the Medi-Cal program standards for participation as established by the director." Based on the contract language and communications with the State, CalOptima Staff understands that its providers do not have to enroll with the State Medi-Cal provider enrollment unit.

CalOptima continues to have obligations to ensure that providers furnishing covered items and services to CalOptima members are contracted and meet federal and state requirements through a standardized credentialing process, including providers who cannot enroll with Medi-Cal (e.g., Health Educators, Dieticians, providers subject to DHCS moratorium, and in-home service providers).

Discussion

CalOptima is responsible for providing access to qualified providers to its members through a standard credentialing process that includes evaluation of many items relevant to quality, integrity and licensure. The attached table compares the differences between those activities that are consistently performed as part of the CalOptima credentialing programs at either CalOptima or by its delegated entities with activities that may occur during the DHCS enrollment process.

Primary care providers in the CalOptima Medi-Cal program also have stringent DHCS defined facility site reviews that include both an inspection of the physical space and evaluation of adherence to certain standards, as well as an evaluation of medical record documentation practices. CalOptima's credentialing process and those of its delegated networks are audited on a routine basis by DHCS, the California Department of Managed Health Care (DMHC) and the Centers for Medicare & Medicaid Services (CMS).

For those providers that enroll with the Medi-Cal program, CalOptima benefits from that process which similarly screens potential CalOptima providers for applicable State and federal requirements and makes ultimate determinations on participation in the Medi-Cal program. Unlike the State, CalOptima does not have similar legal authority or resources to conduct the certain pre-screening and investigative activities related to provider enrollment nor does it have the same statutory authority to summarily suspend providers based on pending investigations and other matters. This responsibility and associated risk will be assumed by CalOptima for certain providers for provision of Medi-Cal services if it does not continue to require Medi-Cal enrollment for excepted providers.

While CalOptima strives to assure providers are qualified to provide services to its Medi-Cal members, it also strives to assure that its members are able to gain access to and have choice of the largest number of providers possible. While there are many CalOptima Direct providers that are currently enrolled in the Medi-Cal program, some are not, and to complete a contracted network, CalOptima needs the flexibility to make exceptions to these enrollment requirements to satisfy its access and continuity of care obligations under its contract with DHCS.

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CalOptima believes that, of the number of active licensed providers (Physicians, Podiatrists, Nurse Practitioners, Optometrists) in Orange County, approximately half are not enrolled in the Medi-Cal program although it is possible that some of these providers may not be entitled to directly bill the Medi-Cal program. The majority of providers that do not enroll in the Medi-Cal program elect to maintain that status for a variety of reasons (including desire to limit their Medi-Cal patients in their practice and avoid the lengthy application process), hence, become unavailable to serve CalOptima Direct and network members, yet they are still eligible to provide services to OneCare and Healthy Families members. Often times, providers who participate in OneCare or Healthy Families will also render services to CalOptima members because they are not aware of the different requirements for each line of business and they are frustrated by the delay or denial of payment for lack of Medi-Cal enrollment.

This policy would exempt providers outside Los Angeles, San Bernardino, Riverside, San Diego and Orange Counties from being enrolled with Medi-Cal or credentialed by CalOptima to be paid by CalOptima for rendering services to its members. It would also allow CalOptima's Chief Medical Officer, and delegated providers in conjunction with the Chief Medical Officer, to use providers who are not enrolled with Medi-Cal to satisfy CalOptima's State Contract requirements to provide proper access to, and continuity of, care for members. Examples of such exemptions may include providers in certain geographic areas which do not have adequate enrolled providers; providers that have unique needed clinical expertise; and providers who see less than five members in a calendar year. These types of providers will still be credentialed by CalOptima and may, in addition, have applications for enrollment in Medi-Cal pending.

In adopting this policy, CalOptima will assume additional responsibilities and liabilities. CalOptima must monitor anti-discrimination; be responsible for provider disciplinary matters; increase screening of providers presently done by Medi-Cal as a part of enrollment compliance; monitor federal/state requirements of its non-enrolled providers including fraud and abuse; and risk of challenge by providers not exempted from the requirement. The monitoring requirements assumed by CalOptima may present problems since DHCS will have limited jurisdiction for any fraud and abuse referrals related to non-enrolled providers. CalOptima has limited ability to investigate, and it cannot prosecute suspected fraud. CalOptima will have to rely on referring such matters to the Attorney General, District Attorney or the applicable State Licensing Board, which may lead to additional costs to investigate and additional risk of investigation or penalty to CalOptima of being out of compliance until the issue is resolved.

Notwithstanding these risks, Management makes the recommended actions outlined in this report to allow required access to providers for CalOptima Medi-Cal members while continuing to require the Medi-Cal enrollment process for the reasons stated herein. CalOptima would have to submit any changes to its provider participation requirements and related policies to DHCS for approval.

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Fiscal Impact

For both medical and administrative expenses, the fiscal impact of this action on the CalOptima budget is not known. For medical expenses, a small number of providers may currently be seeing CalOptima members but not submitting claims because they are not enrolled in the Medi-Cal program. However, neither the number of unsubmitted claims nor the associated dollars are estimated to be material. For additional administrative expenses, management anticipates that they will be absorbed into the Board-approved budget. Such expenses are dependent on several factors. For example, there may be new administrative responsibilities due to the need for CalOptima to take on additional levels of review related to provider enrollment requirements that are not currently part of CalOptima's credentialing program. Also, CalOptima's Compliance Department may have increased obligations and incur additional costs due to the DHCS' Audits & Investigations Unit (A&I) not having jurisdiction over non-enrolled providers should CalOptima identify potential fraud and/or abuse involving non-enrolled providers. Staff will monitor medical and administrative expenses and keep the Board apprised should they prove to be greater than anticipated.

Rationale for Recommendation

Notwithstanding the additional risk and possible administrative costs to CalOptima in allowing exceptions to Medi-Cal enrollment, the recommendations, if adopted, will allow CalOptima expanded access to quality health care service providers consistent with the State Contract who are not presently enrolled in the Medi-Cal program.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachment

Medi-Cal Enrollment and CalOptima Contracting and Credentialing Comparison

/s/ Richard Chambers — *10/1/2010*

Authorized Signature — **Date**

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Medi-Cal Enrollment and CalOptima Contracting and Credentialing Comparison

Category	Item	DHCS FFS	CalOptima Contracted
Information Collected	All Providers	Business Location	Business Location
		Tax ID Number	Tax ID Number
		Licenses	Licenses
		Proof of Insurance	Proof of Insurance
		Business License	*
		Seller's Permits (if req.)	*
		Fictitious Business Name Statement (if app.)	*
		Fines or Debts Owed to Govt. Healthcare Programs	*
		Felony convictions in last ten years	Felony convictions in last ten years
		Misdemeanor convictions involving fraud/abuse in last ten years	*
		Civil liability involving fraud/abuse in last ten years	*
		Settlements in lieu of conviction for fraud/abuse in last ten years	*
		Suspensions from Medi-Cal/Medicare/Medicaid	Suspensions from Medi-Cal/Medicare/Medicaid
		Suspensions/Revocations of license/certificate/approval to provide health care	Suspensions/Revocations of license/certificate/approval to provide health care
		Lost or surrendered license/certificate/approval to provide health care with discipline pending	Lost or surrendered license/certificate/approval to provide health care with discipline pending
		History of discipline re: license/certificate/approval to provide health care	History of discipline re: license/certificate/approval to provide health care
		Ownership/management/control	*
		Subcontractor information	*
		Subcontractor ownership/management/control if over $75K over five years	*
	Group Practices	Group type and specialties	Group type and specialties
		Rendering providers	Rendering providers
		Hospital privileges of rendering providers	
		Suspended or revoked hospital privileges of rendering providers	
		Voluntary resignation or surrender of hospital privileges by rendering providers	
		CLIA certificate number	
		State laboratory license/registration number	

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Category	Item	DHCS FFS	CalOptima Contracted
		Rendering provider application for providers not already enrolled	
		partnership agreement, if partnership	
	Physicians	CLIA certificate number	
		State laboratory license/registration number	
		Hospital privileges	Hospital privileges
		Suspended or revoked hospital privileges	Suspended or revoked hospital privileges
		Voluntary resignation or surrender of hospital privileges	Voluntary resignation or surrender of hospital privileges
			Other previous hospital privileges
			Premed Education
			Medical education
			Internship/PGYI
			Residencies/Fellowships
			Board Certifications
			Other Certifications
			Other state licenses
			Peer references
			Work history
			Student status relinquishment
			Professional organization discipline
			Drug-related impairment
			Disability accommodation
			Malpractice judgments/settlements
			Professional liability insurance termination/non-renewal
	Rendering Providers	Payment arrangement documents	No separate requirements
		DEA certificate	
		Anesthesia permit	
		Conscious sedation permit	
	Hospital-Based Physician	CLIA Certificate number	Exempted
		State laboratory license/registration number	

Category	Item	DHCS FFS	CalOptima Contracted
Independent Verification	As applicable	Professional licensure	Professional licensure
		Criminal history--Applicant, provider and all ownership and control persons	
		Suspensions from government programs	Suspensions from government programs
		Professional discipline	Professional discipline
		Compliance with definition (22 CCR Art. 2, Ch. 3)	
		Compliance with Standards (22 CCR Art.3, Ch. 3 and W&I Ch. 7 and Ch. 8)	
		Business licenses	
		Payment of all outstanding fines and debts to government programs	
		Current FWA investigation status of applicant, providers and all ownership and control persons	
		Onsite inspection	Onsite inspection
		No denial of enrollment in last three years	
			Hospital privileges
			Education
			Board certification
			DEA Certification
			Malpractice claim history
Enforcement Tools	All	Referral to law enforcement	Referral to law enforcement
		Contract remedies	Contract remedies
		Recoupment of Overpayments	Recoupment of Overpayments
		Civil monetary penalties	
		Peace officer status employees in Audits and Investigations	
		Summary deactivations	
		Summary terminations of provisional and preferred provisional providers	
		Sanctions (reprimand/probation/suspension)	

* CalOptima's contract with DHCS requires CalOptima to collect current, completed DHCS Disclosure Form from each subcontractor containing this information.

Credentialing and Provider Participation Requirements

Board of Directors Meeting
October 7, 2010

Gertrude S. Carter, M.D.
Chief Medical Officer

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Medi-Cal Participation History

- Requirement based on Fee-for-Service (FFS) Medi-Cal requirements

- Administrative and business focused assessment
  - Example: location, licensure status, provider's legal standing (see grid)

- FFS Medi-Cal needs:
  a. Screening mechanism to ensure minimum participation standard
  b. Means to facilitate payment
  c. Capability to monitor and enforce legal requirements

CalOptima Participation History

- CalOptima currently requires Medi-Cal participation

- CalOptima credentialing process includes Medi-Cal participation, administrative and business requirements plus significant clinical and quality requirements.
  - Credentialing includes:
    - Education, board certification, affiliation/privileges and clinical performance
    - Facility site review and medical record review

- Former DHCS Contract stated: “Provider shall be eligible for participation in the Medi-Cal Program.”

Current CalOptima Contract

- Current updated Medi-Cal contract language clarifies DHCS position:
  - Exhibit A, Attachment 6 (Provider Network), Provision 12 (Subcontracts)

    "Contractor shall remain accountable for all functions and responsibilities that are delegated to subcontractors. Nothing in this provision shall be construed to require that subcontracting providers be enrolled as a Medi-Cal provider."

Issue

- What should the policy be in those cases where compliance with both requirements are in conflict, specifically when access and quality cannot be met within a Medi-Cal enrolled network?
  - CalOptima has an informal process that is based on medical necessity
  - The informal “exception” policy is not consistent with the current participation policy

Exceptions

- Geographic
  - Availability of service in geographic area
- Clinical service
  - Access to the most appropriate level of experience available
- Continuity of care
  - Maintaining on-going treatment plan
- Member specific need that can drive clinical outcomes
  - Culture
  - Religion
  - Gender

Analysis 2009

- COD Prior Authorization = 30,000

- Letters of Agreement = 906
  - Ambulatory Surgery Centers = 591
  - Hospitals = 197
  - Other Facilities = 50
  - Professional Services = 56
  - Other = 12

Analysis 2009

- Historical (Non Medi-Cal enrolled providers)
  - ➢COD (Registered) = 163 of 4,647 total contracted providers = 3.5%
  - ➢Noble = 9 of 369 total contracted providers = 2.4%
  - ➢CHOC Health Alliance = 6 of 688 total contracted providers = 0.9%
  - ➢Monarch = 72 of 1,532 total contracted providers = 4%

Risk

- CalOptima would have to assume legal and enforcement functions without the State's police powers for those non- Medi-Cal enrolled providers, just as with all other lines of business

- Poses minimum risk because:
  1. Credentialing process
  2. Primary focus is high complex specialty directed providers who have affiliations with tertiary facilities
  3. Low utilization of exceptions
  4. CalOptima oversight activities including both compliance and peer review

Recommendation

Align the informal process with current policy to continue Medi-Cal participation with exceptions that promote access and quality based on medical necessity review.

CalOptima's Mission

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Further Action Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services

Contact

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

Recommended Actions

Authorize the following action related to the requirement that all contracted providers be enrolled in the Medi-Cal program through the Department of Health Care Services (DHCS) by January 1, 2019:

1. Authorize CalOptima to continue contracts with the non-Medi-Cal enrolled contracted providers through December 31, 2019, whose application to the State to become enrolled in the Medi-Cal program remains pending and were submitted to the DHCS prior to January 1, 2019.

Background

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The revised regulation included requirements that providers in Managed Care Plans (MCPs) including CalOptima be subject to the same provider enrollment and screening requirements as providers who participate in Medicaid State fee-for-service programs. Provider enrollment and screening is in addition to credentialing requirements and is meant to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

On November 14, 2017, DHCS issued All Plan Letter (APL) 17-019, which specified MCP's responsibilities related to the screening and enrollment of all Medi-Cal network providers.

Due to the backlog of provider enrollment applications, the State's Medi-Cal enrollment process is taking longer than the six-month period previously authorized by the Board to complete. It is unlikely that all of the approximately 548 CalOptima providers not currently enrolled will complete this process by June 30, 2019. Staff has gathered information on non-enrolled providers currently serving CalOptima Medi-Cal beneficiaries, identifying the number, specialty and potential member impact of terminating provider contracts. In the event that the existing contracts of the remaining 528 currently non-enrolled CalOptima Medi-Cal providers were terminated, the results would affect over 20,939 Members' PCP assignments and more than 7,922 Members who access specialty care. To mitigate this potential disruption to the provider network and assure member's continued access to care, Staff is requesting Board approval of the recommended actions.

Discussion

During the November 8, 2018 CalOptima Board meeting, the Board approved that providers who are not currently enrolled with Medi-Cal but have provided proof to CalOptima that their Medi-Cal provider

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enrollment application and all required information was submitted to the State prior to January 1, 2019, continue as contracted CalOptima participating providers until June 30, 2019. Due to the Board approval to extend these participating providers, 309 providers are now Medi-Cal enrolled.

The prior request indicated that staff will consider returning to the Board with further recommendations in the event that there were further delays in the state's enrollment process. Staff is returning to provide an update on the progress and further recommends that the remaining 548 providers who are not currently enrolled with Medi-Cal but have provided proof that their Medi-Cal provider enrollment application and all required information was submitted to the State prior to January 1, 2019, continue as contracted CalOptima participating providers until such a time as DHCS renders a decision on that provider's Medi-Cal enrollment application, not to extend past December 31, 2019. As noted above, the Medi-Cal enrollment process with the state is taking many months to complete. This is a concern shared by many health plans state wide, with many opting for a similar approach of attempting to minimize member care disruption while the state works through the backlog of provider Medi-Cal enrollment applications, while also working to comply with the prescribed timelines.

While the proposed approach of allowing additional time for the Medi-Cal enrollment process to be completed without reassigning Members from Providers with pending applications to those who have completed the DHCS Medi-Cal provider enrollment process potentially places CalOptima at risk for payment and for DHCS audit findings of CalOptima's non-compliance with the terms of the DHCS-CalOptima contract, as indicated, our understanding is that this is an approach being followed by numerous other plans to allow time for DHCS to work through the backlog of Medi-Cal provider enrollment applications.

Under the proposed approach to continue the contracts with the providers who remain pending in the DHCS Medi-Cal enrollment process, if any such provider is still not Medi-Cal enrolled by December 31, 2019, their contract with CalOptima will be terminated effective January 1, 2020. In addition, all non-enrolled PCPs will continue to have their panels closed to new members until their Medi-Cal enrollment is complete.

As indicated, implementation of these actions without DHCS approval could potentially place CalOptima and other plans throughout the state at risk for any payments made to such non-Medi-Cal enrolled providers and may also result in audit findings from the State, the consequences of which may be corrective action plan(s) and/or sanctions. However, with a focus on ensuring member access to crucial healthcare services, staff recommends proceeding with the proposed approach.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget, approved by the Board on June 7, 2018, includes forecasted professional medical expenses. The recommended action to continue contracts with certain non-Medi-Cal enrolled providers through December 31, 2019, is not projected to result in a material change to the budgeted medical expenses. Therefore, it is a budgeted item with no additional fiscal impact assuming the State takes no actions related to payments made to non-enrolled providers and does not find CalOptima to be non-compliant, issue sanctions or take other related action(s).

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Management will include revenue and expenses for the period of July 1, 2019, through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

Continued access to providers in the process of being enrolled in Medi-Cal and services identified as crucial to avoid barriers in access to care will allow members to receive uninterrupted care notwithstanding the DHCS requirements that all providers enroll in the Medi-Cal program effective January 1, 2019.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS issued All Plan Letter (APL) 17-019
2. Board Action dated November 1, 2018, Consider Authorizing Actions Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services

/s/ Michael Schrader — *4/24/2019*

Authorized Signature — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: November 14, 2017

ALL PLAN LETTER 17-019
SUPERSEDES ALL PLAN LETTER 16-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F,[1] dated May 6, 2016. Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 Code of Federal Regulations (CFR), Section 438.214.[2] This APL supersedes APL 16-012.[3] The screening and enrollment responsibilities are located in Part: 1 and the credentialing and recredentialing responsibilities are located in Part: 2 of this APL.

All MCP network providers must enroll in the Medi-Cal Program. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through the Department of Health Care Services (DHCS). MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018.

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC[4] to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act. The intent of Title 42 CFR, Part 455, Subparts B and E[5] was to reduce the

[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] Title 42 CFR Section 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1214
[3] APL 16-012 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-012.pdf
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] Title 42 CFR, Part 455, Subparts B and E are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

In May 2016, CMS issued rulemaking CMS-2390-F, which extended the provider screening and enrollment requirements of 42 CFR, Part 455, Subparts B and E to MCP contracted providers (Title 42 CFR, Section 438.602(b)). These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

MCPs are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal Program. Title 42 CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers[6] as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards that the Medi-Cal managed care program and MCPs must now implement.[7] Although the implementation date for Title 42 CFR Section 438.602(b) is not scheduled until July 1, 2018, Section 5005(b)(2) of the 21st Century Cures Act (Cures Act),[8] requires managed care network provider enrollment to be implemented by January 1, 2018.

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[9] Credentialing is defined as the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

[6] Exhibit E, Attachment 1 Definitions. The MCP Boilerplate contracts can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[7] State-specific Medi-Cal FFS provider enrollment requirements are contained in Title 22, CCR, Section 51000 through 51051, and Welfare & Institutions Code, Division 9, Part 3, Chapter 7 (commencing with Section 14043).
[8] 42 USC § 1396u-2 (d)(6)(A)
[9] Exhibit A, Attachment 4, Credentialing and Recredentialing.

POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal[10] to obtain a list of currently enrolled Medi-Cal FFS providers. MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through the DHCS enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP may not also participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from, the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through DHCS.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

MCP Enrollment Processes

If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[11] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and

[10] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

[11] Applications packages by provider type can be found at the following: http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types see Title 22 CCR 51000 – 51000.26 and 51051.

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completeness. MCPs must ensure that all information specified in Title 22, California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments to the application package have been received. The MCP must obtain the provider's consent in order for DHCS and the MCP to share information relating to the provider's application and eligibility, including but not limited to issues related to program integrity.

MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[12] The application fee for calendar year 2017 is $560. Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. DHCS Provider Enrollment Agreement and Plan Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state (DHCS Provider Enrollment Agreement) as a condition of participating in the Medi-Cal Program pursuant to Section 1902(a)(27) of the Social Security Act and Section 14043.1 of the Welfare & Institutions Code. As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the DHCS Provider Enrollment Agreement. This provider agreement is separate and distinct from the Plan Provider Agreement (see below). MCPs must maintain the original signed DHCS Provider Enrollment Agreement for each provider and must submit a copy to DHCS, CMS, and other appropriate agencies upon request. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and place that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Plan Provider Agreement) is separate and distinct from the DHCS Provider Enrollment Agreement. Both the DHCS Provider Enrollment Agreement and the Plan Provider Agreement are required for MCP network providers. The DHCS Provider Enrollment Agreement does not expand or alter the MCP's existing rights or obligations relating to its Plan Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42, CFR, Sections 455.104, 455.105, and 455.106, and Title 22, CCR, Section 51000.35. Providers who are unincorporated sole-proprietors are not required to

[12] Application Fee information is available at: http://www.dhcs.ca.gov/provgovpart/Pages/AppFeeChange2017.aspx

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disclose the ownership or control information described in Title 42, CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42, CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal Program. These disclosures must be provided when:

- A prospective provider submits the provider enrollment application.
- A provider executes the DHCS Provider Enrollment Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[13]

Additionally, MCPs must comply with the requirements contained in Title 22, CCR, Section 51000.35, Disclosure Requirements. MCPs are not required to utilize the DHCS disclosure forms (DHCS 6207 and 6216[14]); however, MCPs must collect all information and documentation required by Title 22, CCR, Section 51000.35.

D. "Limited," "Moderate," "High" Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as "limited," "moderate," or "high." If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening requirements and for MCPs to stratify their network providers by risk level are set forth in Attachment 1 to this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs are

[13] 42 CFR 455.105(b)
[14] DHCS Forms 6207 and 6216 are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

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not able to enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements.
- Hold a license certified for practice in the state and has no limitations from other states.
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers:

- Screening requirements of limited-risk providers.
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers.
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers - Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a

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5% or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[15] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. DHCS will make a pre-filled Live Scan form available to all MCPs to distribute to providers. When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22, CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. In addition, all providers enrolled in the Medi-Cal Program, including providers enrolled through MCPs,[16] are subject to unannounced onsite inspections at all provider locations.

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal Program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[15] Welfare and Institutions Code 14043.38(c)(2)
[16] 42 CFR 455.432

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G. Federal and State Database Checks

During the provider enrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File.[17]
- National Plan and Provider Enumeration System (NPPES).[18]
- List of Excluded Individuals/Entities (LEIE).[19]
- System for Award Management (SAM).[20]
- CMS' Medicare Exclusion Database (MED).[21]
- DHCS' Suspended and Ineligible Provider List.[22]

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal Managed Care Program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment, that may impact the provider's eligibility to participate in the Medi-Cal Program, or a provider refuses to submit to the required screening activities,[23] the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal Program.

If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[24]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[25]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and

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[17] Social Security Administration's Death Master File is available at: https://www.ssdmf.com/
[18] NPPES is available at: https://nppes.cms.hhs.gov
[19] LEIE is available at: https://oig.hhs.gov/exclusions/exclusions_list.asp
[20] SAM is available at: https://www.sam.gov
[21] MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html
[22] Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[23] 42 CFR 455.416
[24] Provider Enrollment information can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx.
[25] 42 CFR 455.422

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DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement (Attachment 2), which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment 2. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- Notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through the DHCS' Medi-Cal FFS provider enrollment process.
- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS Program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their limited-risk and medium-risk network providers at least every five years,[26] and their high-risk network providers every three years. MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

[26] 42 CFR 455.414

Data Base Checks
MCPs must review the SAM and LEIE databases on a monthly basis. All other databases must be reviewed upon a provider's reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal Programs; any provider terminated from the Medicare or Medicaid/Medi-Cal Program may not participate in the MCP's provider network.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[27] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process, in accordance with Title 42, CFR, Section 438.602(b)(2).

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements

MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing

[27] 42 CFR 438.3(u)

body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing

MCPs are required to verify the credentials of their contracted medical providers, and to verify the following items, as required for the particular provider type, through a primary source,[28] as applicable:[29]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[30]

[28] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[29] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.
[30] National Practitioner Data Bank is available at: https://www.ncsbn.org/418.htm.

- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List may not participate in the MCP's provider network.[31]
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

Attestations

For all medical service provider types who deliver Medi-Cal-covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[32]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities serious quality deficiencies that result in suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites. For detailed guidance, see Policy Letter (PL) 14-004, Site Reviews, Facility Site Review and Medical

[31] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

[32] These limited statements comply with requirements of the Americans with Disabilities Act (ADA), as discussed in the attached PL 02-03. The ADA Attachment is available at (pg. 7): http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf.

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Record Review,[33] and any subsequent revisions to this PL. MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. MCPs; however, retain overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

[33] Policy Letter 14-004 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf

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MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including applicable APLs, PLs and Dual Plan Letters. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

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Attachment 1: Provider Types and Categories of Risk[34]/Screening Requirements

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities

[34] CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations

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- Non-public, non-government owned or affiliated ambulance services suppliers
    - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.

(3) High Risk Provider Types. Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.

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Attachment 2: Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

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application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.

- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS.

- The provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Actions Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services

Contact

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

Recommended Actions

Authorize the following actions related to the requirement that all contracted providers be enrolled in the Medi-Cal program through the Department of Health Care Services (DHCS) by January 1, 2019:

1. Authorize CalOptima to continue to contract with non-Medi-Cal enrolled providers through June 30, 2019, subject to CalOptima's receipt of proof that each such provider's application to the State to become enrolled in the Medi-Cal program was submitted to the DHCS prior to January 1, 2019; and
2. Authorize Letters of Agreement (LOA) with non-Medi-Cal enrolled specialist providers identified by the Chief Medical Officer through December 31, 2019 as required for access to services or continuity of care.

Background

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The revised regulation included requirements that providers in Managed Care Plans (MCPs) including CalOptima be subject to the same provider enrollment and screening requirements as providers who participate in Medicaid State fee-for-service programs. Provider enrollment and screening is in addition to credentialing requirements and is meant to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

On November 14, 2017, DHCS issued All Plan Letter (APL) 17-019, which specified MCP's responsibilities related to the screening and enrollment of all Medi-Cal network providers.

The contract between DHCS and CalOptima effective January 1, 2009, discontinued the requirement that providers be eligible for participation in the Medi-Cal Program. However, on October 7, 2010, the CalOptima Board of Directors approved the continuation of a policy which requires that providers furnishing services to CalOptima Medi-Cal members be enrolled with the State of California's Medi-Cal Program when an enrollment path with the State is available for the provider. In recognition that not all providers eligible to enroll with Medi-Cal would enroll, the Board also approved a policy allowing the Chief Medical Officer, or delegated providers in conjunction with the Chief Medical Officer, to make exceptions to this policy to satisfy access and continuity of care requirements in CalOptima's contract with DHCS.

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Although the new state mandated enrollment and screening requirements were effective January 1, 2018, DHCS guidance clarified that non-enrolled providers contracted with the MCPs prior to this date, have until December 31, 2018 to complete the process. Presumably, providers not enrolled by his date are to be terminated as a MCP participating provider for Medi-Cal services. Staff continues to review provider data to determine the number of non-enrolled providers and the potential impact to the members who are in their care should these providers no longer be available in the future due to their non-enrolled status.

DHCS specifies that provider screening and enrollment can be accomplished in two ways. MCPs may direct providers to the Medi-Cal enrollment division of DHCS for screening and enrollment, or MCPs may develop and implement an internal screening and enrollment process that meets the requirements of the APL. Due to the numerous additional requirements associated with the enrollment and screening process and the expertise required to fulfill these requirements, CalOptima staff believes it is more appropriate to continue to depend on the State's process to assure providers are properly vetted for Medi-Cal participation rather than to develop a duplicative process that would, in any case, lack the breadth of potentially relevant information available to the State, but not necessarily available to CalOptima.

Staff continues to conduct extensive outreach efforts to encourage non-enrolled providers to seek enrollment in the Medi-Cal program and continued participation with CalOptima. The outreach efforts have been successful, and Staff has identified the addition of over 900 previously non-enrolled providers since April 2018.

However, because the State's Medi-Cal enrollment process can take up to 180 days to complete, it is unlikely that all of the approximately 1,200 CalOptima providers not currently enrolled will complete this process by the end of the calendar year. Staff has gathered information on non-enrolled providers currently serving CalOptima Medi-Cal beneficiaries, identifying the number, specialty and potential member impact of terminating provider contracts. In the event that the existing contracts of all 1,200 currently non-enrolled CalOptima Medi-Cal providers were terminated, the results would be significant, affecting over 26,0000 Members' PCP assignments and more than 10,000 Members who access specialty care. To mitigate this potential disruption to the provider network and assure member's continued access to care, Staff is requesting Board approval of the recommended actions.

Discussion

Staff recommends that providers who are not currently enrolled with Medi-Cal but can provide proof that their Medi-Cal provider enrollment application and all required information has been submitted to the State prior to January 1, 2019, continue as contracted CalOptima participating providers until such a time as DHCS renders a decision on that provider's Medi-Cal enrollment application, potentially through June 30, 2019. As noted above, the Medi-Cal enrollment process with the state may take up to 180 days. This is a concern shared by many health plans state wide, with many opting for a similar approach of attempting to minimize member care disruption while the state works through the backlog of provider Medi-Cal enrollment applications, while also working to comply with the prescribed timelines.

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While the proposed approach of allowing additional time for the Medi-Cal enrollment process to be completed without reassigning Members from Providers with pending applications to those who have completed the DHCS Medi-Cal provider enrollment process potentially places CalOptima at risk for payment and for DHCS audit findings of CalOptima's non-compliance with the terms of the DHCS-CalOptima contract, as indicated, our understanding is that this is an approach being followed by numerous other plans to allow time for DHCS to work through the backlog of Medi-Cal provider enrollment applications.

Under the proposed approach, if any such provider is still not Medi-Cal enrolled by June 30, 2019, their contract with CalOptima will be not be extended thereafter. In addition, all non-enrolled PCPs will have their panels closed to new members until their Medi-Cal enrollment is complete. Should the provider still be in the enrollment process by June 30, 2019 (i.e., application submitted to the state on or before December 31, 2018, but state review process not having been finalized as of June 30, 2018), Staff will consider returning to the Board with further recommendations. This scenario would only be a possibility in the event that there were further delays in the state's enrollment process.

Apart from those providers who have indicated that they plan to submit their Medi-Cal enrollment applications on or before December 31, 2018, staff has identified members in care with non-enrolled providers who are required for access and may choose not to apply to enroll in Medi-Cal. The impact of terminating these providers could create barriers to access sensitive or highly specialized services and/or redirecting members to other providers may be disruptive to member care. Staff proposes to proactively pursue LOAs with these terminated providers to allow for uninterrupted access by Members for whom there is not a suitable alternative contracted provider at this time. DHCS has advised MCPs that MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis. COC requests would be processed in accordance with CalOptima's DHCS-approved policies on the topic. Staff plans to proactively identify members in care with non-enrolled providers required for access; subject to Board approval, Staff will enter into LOAs for members currently in care with these providers to enable members and providers to continue uninterrupted care as longer-term efforts are undertaken to ensure that, member care is being provided by Medi-Cal enrolled providers.

As indicated, implementation of these actions without DHCS approval could place potentially place CalOptima and other plans throughout the state at risk for any payments made to such non-Medi-Cal enrolled providers and may also result in audit findings from the State, the consequences of which may be corrective action plan(s) and/or sanctions. However, with a focus on ensuring member access to crucial healthcare services, staff recommends proceeding with the proposed approach.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget, approved by the Board on June 7, 2018, includes forecasted professional medical expenses. The recommended actions to continue contracts with certain non-Medi-Cal enrolled providers through June 30, 2019, and issue to certain specialist providers are not projected to result in a material change to the budgeted medical expenses. Therefore, the recommended actions are budgeted items with no additional fiscal impact assuming the State takes

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no actions related to payments made to non-enrolled providers and does not find CalOptima to be non-compliant and issue sanctions or take other related action(s).

Management will include revenue and expenses for the period of July 1, 2019, through December 31, 2019, related to the LOAs with certain specialist providers in future operating budgets.

Rationale for Recommendation

Continued access to providers in the process of being enrolled in Medi-Cal and services identified as crucial to avoid barriers in access to care will allow members to receive uninterrupted care notwithstanding the DHCS requirements that all providers enroll in the Medi-Cal program effective January 1, 2019.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS issued All Plan Letter (APL) 17-019
2. CalOptima Board Action dated October 7, 2010, Authorize Revisions to Credentialing and Provider Participation Requirements in CalOptima's Medi-Cal Program

/s/ Michael Schrader — **Authorized Signature**

10/24/2018 — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: November 14, 2017

ALL PLAN LETTER 17-019
SUPERSEDES ALL PLAN LETTER 16-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F,[1] dated May 6, 2016. Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 Code of Federal Regulations (CFR), Section 438.214.[2] This APL supersedes APL 16-012.[3] The screening and enrollment responsibilities are located in Part: 1 and the credentialing and recredentialing responsibilities are located in Part: 2 of this APL.

All MCP network providers must enroll in the Medi-Cal Program. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through the Department of Health Care Services (DHCS). MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018.

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC[4] to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act. The intent of Title 42 CFR, Part 455, Subparts B and E[5] was to reduce the

[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] Title 42 CFR Section 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1214
[3] APL 16-012 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-012.pdf
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] Title 42 CFR, Part 455, Subparts B and E are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

In May 2016, CMS issued rulemaking CMS-2390-F, which extended the provider screening and enrollment requirements of 42 CFR, Part 455, Subparts B and E to MCP contracted providers (Title 42 CFR, Section 438.602(b)). These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

MCPs are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal Program. Title 42 CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers[6] as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards that the Medi-Cal managed care program and MCPs must now implement.[7] Although the implementation date for Title 42 CFR Section 438.602(b) is not scheduled until July 1, 2018, Section 5005(b)(2) of the 21st Century Cures Act (Cures Act),[8] requires managed care network provider enrollment to be implemented by January 1, 2018.

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[9] Credentialing is defined as the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

[6] Exhibit E, Attachment 1 Definitions. The MCP Boilerplate contracts can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[7] State-specific Medi-Cal FFS provider enrollment requirements are contained in Title 22, CCR, Section 51000 through 51051, and Welfare & Institutions Code, Division 9, Part 3, Chapter 7 (commencing with Section 14043).
[8] 42 USC § 1396u-2 (d)(6)(A)
[9] Exhibit A, Attachment 4, Credentialing and Recredentialing.

POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal[10] to obtain a list of currently enrolled Medi-Cal FFS providers. MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through the DHCS enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP may not also participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from, the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through DHCS.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

MCP Enrollment Processes

If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[11] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and

[10] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

[11] Applications packages by provider type can be found at the following: http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types see Title 22 CCR 51000 – 51000.26 and 51051.

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completeness. MCPs must ensure that all information specified in Title 22, California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments to the application package have been received. The MCP must obtain the provider's consent in order for DHCS and the MCP to share information relating to the provider's application and eligibility, including but not limited to issues related to program integrity.

MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[12] The application fee for calendar year 2017 is $560. Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. DHCS Provider Enrollment Agreement and Plan Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state (DHCS Provider Enrollment Agreement) as a condition of participating in the Medi-Cal Program pursuant to Section 1902(a)(27) of the Social Security Act and Section 14043.1 of the Welfare & Institutions Code. As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the DHCS Provider Enrollment Agreement. This provider agreement is separate and distinct from the Plan Provider Agreement (see below). MCPs must maintain the original signed DHCS Provider Enrollment Agreement for each provider and must submit a copy to DHCS, CMS, and other appropriate agencies upon request. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and place that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Plan Provider Agreement) is separate and distinct from the DHCS Provider Enrollment Agreement. Both the DHCS Provider Enrollment Agreement and the Plan Provider Agreement are required for MCP network providers. The DHCS Provider Enrollment Agreement does not expand or alter the MCP's existing rights or obligations relating to its Plan Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42, CFR, Sections 455.104, 455.105, and 455.106, and Title 22, CCR, Section 51000.35. Providers who are unincorporated sole-proprietors are not required to

[12] Application Fee information is available at: http://www.dhcs.ca.gov/provgovpart/Pages/AppFeeChange2017.aspx

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disclose the ownership or control information described in Title 42, CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42, CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal Program. These disclosures must be provided when:

- A prospective provider submits the provider enrollment application.
- A provider executes the DHCS Provider Enrollment Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[13]

Additionally, MCPs must comply with the requirements contained in Title 22, CCR, Section 51000.35, Disclosure Requirements. MCPs are not required to utilize the DHCS disclosure forms (DHCS 6207 and 6216[14]); however, MCPs must collect all information and documentation required by Title 22, CCR, Section 51000.35.

D. "Limited," "Moderate," "High" Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as "limited," "moderate," or "high." If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening requirements and for MCPs to stratify their network providers by risk level are set forth in Attachment 1 to this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs are

[13] 42 CFR 455.105(b)
[14] DHCS Forms 6207 and 6216 are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

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not able to enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements.
- Hold a license certified for practice in the state and has no limitations from other states.
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers:

- Screening requirements of limited-risk providers.
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers.
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers - Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a

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5% or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[15] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. DHCS will make a pre-filled Live Scan form available to all MCPs to distribute to providers. When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22, CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. In addition, all providers enrolled in the Medi-Cal Program, including providers enrolled through MCPs,[16] are subject to unannounced onsite inspections at all provider locations.

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal Program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[15] Welfare and Institutions Code 14043.38(c)(2)
[16] 42 CFR 455.432

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G. Federal and State Database Checks

During the provider enrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File.[17]
- National Plan and Provider Enumeration System (NPPES).[18]
- List of Excluded Individuals/Entities (LEIE).[19]
- System for Award Management (SAM).[20]
- CMS' Medicare Exclusion Database (MED).[21]
- DHCS' Suspended and Ineligible Provider List.[22]

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal Managed Care Program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment, that may impact the provider's eligibility to participate in the Medi-Cal Program, or a provider refuses to submit to the required screening activities,[23] the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal Program.

If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[24]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[25]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and

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[17] Social Security Administration's Death Master File is available at: https://www.ssdmf.com/
[18] NPPES is available at: https://nppes.cms.hhs.gov
[19] LEIE is available at: https://oig.hhs.gov/exclusions/exclusions_list.asp
[20] SAM is available at: https://www.sam.gov
[21] MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html
[22] Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[23] 42 CFR 455.416
[24] Provider Enrollment information can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx.
[25] 42 CFR 455.422

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DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement (Attachment 2), which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment 2. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- Notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through the DHCS' Medi-Cal FFS provider enrollment process.
- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS Program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their limited-risk and medium-risk network providers at least every five years,[26] and their high-risk network providers every three years. MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

[26] 42 CFR 455.414

Data Base Checks
MCPs must review the SAM and LEIE databases on a monthly basis. All other databases must be reviewed upon a provider's reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal Programs; any provider terminated from the Medicare or Medicaid/Medi-Cal Program may not participate in the MCP's provider network.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[27] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process, in accordance with Title 42, CFR, Section 438.602(b)(2).

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements

MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing

[27] 42 CFR 438.3(u)

body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing

MCPs are required to verify the credentials of their contracted medical providers, and to verify the following items, as required for the particular provider type, through a primary source,[28] as applicable:[29]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[30]

[28] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[29] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.
[30] National Practitioner Data Bank is available at: https://www.ncsbn.org/418.htm.

- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List may not participate in the MCP's provider network.[31]
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

Attestations

For all medical service provider types who deliver Medi-Cal-covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[32]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities serious quality deficiencies that result in suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites. For detailed guidance, see Policy Letter (PL) 14-004, Site Reviews, Facility Site Review and Medical

[31] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

[32] These limited statements comply with requirements of the Americans with Disabilities Act (ADA), as discussed in the attached PL 02-03. The ADA Attachment is available at (pg. 7): http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf.

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Record Review,[33] and any subsequent revisions to this PL. MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. MCPs; however, retain overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

[33] Policy Letter 14-004 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf

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MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including applicable APLs, PLs and Dual Plan Letters. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

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Attachment 1: Provider Types and Categories of Risk[34]/Screening Requirements

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities

[34] CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations

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- Non-public, non-government owned or affiliated ambulance services suppliers
    - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.

(3) High Risk Provider Types. Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.

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Attachment 2: Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

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application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.

- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS.

- The provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2010
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Authorize Revisions to Credentialing and Provider Participation Requirements in CalOptima's Medi-Cal Program

Contact

Gertrude S. Carter, M.D., Chief Medical Officer, (714) 246-8400
Greg Buchert, M.D., MPH, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Approve policy continuing the requirement that providers furnishing services to CalOptima Medi-Cal members be enrolled in the State of California Medi-Cal Program when enrollment is available for that type of provider;
2. Approve an exception to that Policy for providers outside of Orange, Los Angeles, San Bernardino, Riverside and San Diego Counties;
3. Approve policy that the Chief Medical Officer or delegate, and delegated providers have the ability to make exceptions to the policy identified in Recommended Action No. 1 to satisfy access and continuity of care requirements in CalOptima's contract with the California Department of Health Care Services (DHCS);
4. Approve policy that providers credentialed by CalOptima or its delegated providers that furnish services, goods or supplies to Healthy Families or OneCare members are encouraged, but not required to, enroll in the State of California Medi-Cal program;
5. Eliminate the Minimum Practitioner Standards (MPS) Policy and requirement for applicable physicians to complete the MPS form prior to credentialing; and,
6. Approve changes to CalOptima's policies to reflect the changes made in this CalOptima Board Action Agenda Referral.

Background

CalOptima contracts directly with providers, or with delegated entities to arrange for providers, to render services to its members. For CalOptima's Healthy Families and OneCare programs, the providers' qualifications are evaluated by standardized credentialing processes that are consistent with NCQA standards and if deemed qualified, can provide services and bill for those services. CalOptima requires the California Department of Health Care Services (DHCS) statutory process related to authorized categories of persons and entities that provide services, goods, and supplies to Medi-Cal recipients. The State process is intended to ensure that provider practices are consistent with sound fiscal and business practices and do not result in unnecessary cost to the State Medi-Cal program and that the State/CalOptima do not have to reimburse the State or CMS for ineligible providers. The State also requires that a provider meet federal disclosure requirements including, without limitation, those related to the provider's licensure, control and ownership interests, and health care program participation status. In reviewing

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provider applications, the State has the authority to conduct unannounced visits, pre-enrollment inspections, background checks and access government resources related to convictions, pending investigations and the status of debts and penalties, if any, owed to government entities.

The State has also established enrollment moratoriums related to specific provider types throughout the State or within specific counties in order to "safeguard public funds and maintain the fiscal integrity of the Medi-Cal program." For example, the State has a moratorium on enrollment of durable medical equipment suppliers (with exceptions) that expressly includes Orange, Los Angeles, Riverside and San Bernardino Counties. Significantly, the State provider enrollment laws incorporate the State's right to summarily deny or suspend a provider's enrollment status, for example, where there are pending allegations of fraud or abuse or investigations related to same.

Prior to January 1, 2009, CalOptima's State Medi-Cal contract with the DHCS required that "each provider who delivers Covered Services to Members shall *be eligible* for participation in the Medi-Cal program and shall meet applicable requirements established under Titles XVIII and XIX of the Social services Act unless exempted from these provisions." The State's enrollment process may take as long as twelve months for a provider to receive acknowledgement of enrollment. While most providers complied with this requirement, some providers discontinued attempting to be paid for services rendered or refused to provide future services to CalOptima members.

In addition to standard credentialing requirements for all providers and the supplemental Medi-Cal enrollment procedure for providers in certain CalOptima medical delivery systems, CalOptima initiated a requirement for providers to supply additional information in order to be paid by CalOptima – the Minimum Practitioner Standards (MPS) form based on the CalOptima Board-approved policy. This policy was adopted in part to allow for a contracted COD network and to provide a basis of denying provider participation without the necessity of a formal statutorily-required hearing for providers who could not meet the standards. All questions of this seven question form request identical information that is included on credentialing applications. Eliminating the MPS form may result in the CalOptima having to file a notice to the Medical Board of California (an "805" report) for COD or Hospital Risk providers in the Medi-Cal program for which CalOptima takes certain actions based on a medical or disciplinary cause or reason. This requirement already exists for PHCs, HMOs, and SRGs in the CalOptima Healthy Families and OneCare programs.

CalOptima entered into a new State Medi-Cal contract with DHCS on January 1, 2009. The contract *no longer* includes language requiring "each provider who delivers Covered Services to Members shall be eligible for participation in the Medi-Cal program and shall meet applicable requirements established under Titles XVIII and XIX of the Social Services Act unless exempted from these provisions." The new 2009 State Medi-Cal contract also includes the following language: "Nothing in this provision shall be construed to require that subcontracting providers be enrolled as a Medi-Cal provider." The new State Medi-Cal contract does incorporate a

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Prepaid Health Plan statute which expressly prohibits contracts between DHCS and PHPs "unless the providers and the facilities of the prepaid health plan meet the Medi-Cal program standards for participation as established by the director." Based on the contract language and communications with the State, CalOptima Staff understands that its providers do not have to enroll with the State Medi-Cal provider enrollment unit.

CalOptima continues to have obligations to ensure that providers furnishing covered items and services to CalOptima members are contracted and meet federal and state requirements through a standardized credentialing process, including providers who cannot enroll with Medi-Cal (e.g., Health Educators, Dieticians, providers subject to DHCS moratorium, and in-home service providers).

Discussion

CalOptima is responsible for providing access to qualified providers to its members through a standard credentialing process that includes evaluation of many items relevant to quality, integrity and licensure. The attached table compares the differences between those activities that are consistently performed as part of the CalOptima credentialing programs at either CalOptima or by its delegated entities with activities that may occur during the DHCS enrollment process.

Primary care providers in the CalOptima Medi-Cal program also have stringent DHCS defined facility site reviews that include both an inspection of the physical space and evaluation of adherence to certain standards, as well as an evaluation of medical record documentation practices. CalOptima's credentialing process and those of its delegated networks are audited on a routine basis by DHCS, the California Department of Managed Health Care (DMHC) and the Centers for Medicare & Medicaid Services (CMS).

For those providers that enroll with the Medi-Cal program, CalOptima benefits from that process which similarly screens potential CalOptima providers for applicable State and federal requirements and makes ultimate determinations on participation in the Medi-Cal program. Unlike the State, CalOptima does not have similar legal authority or resources to conduct the certain pre-screening and investigative activities related to provider enrollment nor does it have the same statutory authority to summarily suspend providers based on pending investigations and other matters. This responsibility and associated risk will be assumed by CalOptima for certain providers for provision of Medi-Cal services if it does not continue to require Medi-Cal enrollment for excepted providers.

While CalOptima strives to assure providers are qualified to provide services to its Medi-Cal members, it also strives to assure that its members are able to gain access to and have choice of the largest number of providers possible. While there are many CalOptima Direct providers that are currently enrolled in the Medi-Cal program, some are not, and to complete a contracted network, CalOptima needs the flexibility to make exceptions to these enrollment requirements to satisfy its access and continuity of care obligations under its contract with DHCS.

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CalOptima believes that, of the number of active licensed providers (Physicians, Podiatrists, Nurse Practitioners, Optometrists) in Orange County, approximately half are not enrolled in the Medi-Cal program although it is possible that some of these providers may not be entitled to directly bill the Medi-Cal program. The majority of providers that do not enroll in the Medi-Cal program elect to maintain that status for a variety of reasons (including desire to limit their Medi-Cal patients in their practice and avoid the lengthy application process), hence, become unavailable to serve CalOptima Direct and network members, yet they are still eligible to provide services to OneCare and Healthy Families members. Often times, providers who participate in OneCare or Healthy Families will also render services to CalOptima members because they are not aware of the different requirements for each line of business and they are frustrated by the delay or denial of payment for lack of Medi-Cal enrollment.

This policy would exempt providers outside Los Angeles, San Bernardino, Riverside, San Diego and Orange Counties from being enrolled with Medi-Cal or credentialed by CalOptima to be paid by CalOptima for rendering services to its members. It would also allow CalOptima's Chief Medical Officer, and delegated providers in conjunction with the Chief Medical Officer, to use providers who are not enrolled with Medi-Cal to satisfy CalOptima's State Contract requirements to provide proper access to, and continuity of, care for members. Examples of such exemptions may include providers in certain geographic areas which do not have adequate enrolled providers; providers that have unique needed clinical expertise; and providers who see less than five members in a calendar year. These types of providers will still be credentialed by CalOptima and may, in addition, have applications for enrollment in Medi-Cal pending.

In adopting this policy, CalOptima will assume additional responsibilities and liabilities. CalOptima must monitor anti-discrimination; be responsible for provider disciplinary matters; increase screening of providers presently done by Medi-Cal as a part of enrollment compliance; monitor federal/state requirements of its non-enrolled providers including fraud and abuse; and risk of challenge by providers not exempted from the requirement. The monitoring requirements assumed by CalOptima may present problems since DHCS will have limited jurisdiction for any fraud and abuse referrals related to non-enrolled providers. CalOptima has limited ability to investigate, and it cannot prosecute suspected fraud. CalOptima will have to rely on referring such matters to the Attorney General, District Attorney or the applicable State Licensing Board, which may lead to additional costs to investigate and additional risk of investigation or penalty to CalOptima of being out of compliance until the issue is resolved.

Notwithstanding these risks, Management makes the recommended actions outlined in this report to allow required access to providers for CalOptima Medi-Cal members while continuing to require the Medi-Cal enrollment process for the reasons stated herein. CalOptima would have to submit any changes to its provider participation requirements and related policies to DHCS for approval.

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Fiscal Impact

For both medical and administrative expenses, the fiscal impact of this action on the CalOptima budget is not known. For medical expenses, a small number of providers may currently be seeing CalOptima members but not submitting claims because they are not enrolled in the Medi-Cal program. However, neither the number of unsubmitted claims nor the associated dollars are estimated to be material. For additional administrative expenses, management anticipates that they will be absorbed into the Board-approved budget. Such expenses are dependent on several factors. For example, there may be new administrative responsibilities due to the need for CalOptima to take on additional levels of review related to provider enrollment requirements that are not currently part of CalOptima's credentialing program. Also, CalOptima's Compliance Department may have increased obligations and incur additional costs due to the DHCS' Audits & Investigations Unit (A&I) not having jurisdiction over non-enrolled providers should CalOptima identify potential fraud and/or abuse involving non-enrolled providers. Staff will monitor medical and administrative expenses and keep the Board apprised should they prove to be greater than anticipated.

Rationale for Recommendation

Notwithstanding the additional risk and possible administrative costs to CalOptima in allowing exceptions to Medi-Cal enrollment, the recommendations, if adopted, will allow CalOptima expanded access to quality health care service providers consistent with the State Contract who are not presently enrolled in the Medi-Cal program.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachment

Medi-Cal Enrollment and CalOptima Contracting and Credentialing Comparison

/s/ Richard Chambers — *10/1/2010*

Authorized Signature — **Date**

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Medi-Cal Enrollment and CalOptima Contracting and Credentialing Comparison

Category	Item	DHCS FFS	CalOptima Contracted
Information Collected	All Providers	Business Location	Business Location
		Tax ID Number	Tax ID Number
		Licenses	Licenses
		Proof of Insurance	Proof of Insurance
		Business License	*
		Seller's Permits (if req.)	*
		Fictitious Business Name Statement (if app.)	*
		Fines or Debts Owed to Govt. Healthcare Programs	*
		Felony convictions in last ten years	Felony convictions in last ten years
		Misdemeanor convictions involving fraud/abuse in last ten years	*
		Civil liability involving fraud/abuse in last ten years	*
		Settlements in lieu of conviction for fraud/abuse in last ten years	*
		Suspensions from Medi-Cal/Medicare/Medicaid	Suspensions from Medi-Cal/Medicare/Medicaid
		Suspensions/Revocations of license/certificate/approval to provide health care	Suspensions/Revocations of license/certificate/approval to provide health care
		Lost or surrendered license/certificate/approval to provide health care with discipline pending	Lost or surrendered license/certificate/approval to provide health care with discipline pending
		History of discipline re: license/certificate/approval to provide health care	History of discipline re: license/certificate/approval to provide health care
		Ownership/management/control	*
		Subcontractor information	*
		Subcontractor ownership/management/control if over $75K over five years	*
	Group Practices	Group type and specialties	Group type and specialties
		Rendering providers	Rendering providers
		Hospital privileges of rendering providers	
		Suspended or revoked hospital privileges of rendering providers	
		Voluntary resignation or surrender of hospital privileges by rendering providers	
		CLIA certificate number	
		State laboratory license/registration number	

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Category	Item	DHCS FFS	CalOptima Contracted
		Rendering provider application for providers not already enrolled	
		partnership agreement, if partnership	
	Physicians	CLIA certificate number	
		State laboratory license/registration number	
		Hospital privileges	Hospital privileges
		Suspended or revoked hospital privileges	Suspended or revoked hospital privileges
		Voluntary resignation or surrender of hospital privileges	Voluntary resignation or surrender of hospital privileges
			Other previous hospital privileges
			Premed Education
			Medical education
			Internship/PGYI
			Residencies/Fellowships
			Board Certifications
			Other Certifications
			Other state licenses
			Peer references
			Work history
			Student status relinquishment
			Professional organization discipline
			Drug-related impairment
			Disability accommodation
			Malpractice judgments/settlements
			Professional liability insurance termination/non-renewal
	Rendering Providers	Payment arrangement documents	No separate requirements
		DEA certificate	
		Anesthesia permit	
		Conscious sedation permit	
	Hospital-Based Physician	CLIA Certificate number	Exempted
		State laboratory license/registration number	

Category	Item	DHCS FFS	CalOptima Contracted
Independent Verification	As applicable	Professional licensure	Professional licensure
		Criminal history--Applicant, provider and all ownership and control persons	
		Suspensions from government programs	Suspensions from government programs
		Professional discipline	Professional discipline
		Compliance with definition (22 CCR Art. 2, Ch. 3)	
		Compliance with Standards (22 CCR Art.3, Ch. 3 and W&I Ch. 7 and Ch. 8)	
		Business licenses	
		Payment of all outstanding fines and debts to government programs	
		Current FWA investigation status of applicant, providers and all ownership and control persons	
		Onsite inspection	Onsite inspection
		No denial of enrollment in last three years	
			Hospital privileges
			Education
			Board certification
			DEA Certification
			Malpractice claim history
Enforcement Tools	All	Referral to law enforcement	Referral to law enforcement
		Contract remedies	Contract remedies
		Recoupment of Overpayments	Recoupment of Overpayments
		Civil monetary penalties	
		Peace officer status employees in Audits and Investigations	
		Summary deactivations	
		Summary terminations of provisional and preferred provisional providers	
		Sanctions (reprimand/probation/suspension)	

* CalOptima's contract with DHCS requires CalOptima to collect current, completed DHCS Disclosure Form from each subcontractor containing this information.

Credentialing and Provider Participation Requirements

Board of Directors Meeting
October 7, 2010

Gertrude S. Carter, M.D.
Chief Medical Officer

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Medi-Cal Participation History

- Requirement based on Fee-for-Service (FFS) Medi-Cal requirements

- Administrative and business focused assessment
  - Example: location, licensure status, provider's legal standing (see grid)

- FFS Medi-Cal needs:
  a. Screening mechanism to ensure minimum participation standard
  b. Means to facilitate payment
  c. Capability to monitor and enforce legal requirements

CalOptima Participation History

- CalOptima currently requires Medi-Cal participation

- CalOptima credentialing process includes Medi-Cal participation, administrative and business requirements plus significant clinical and quality requirements.
  - Credentialing includes:
    - Education, board certification, affiliation/privileges and clinical performance
    - Facility site review and medical record review

- Former DHCS Contract stated: “Provider shall be eligible for participation in the Medi-Cal Program.”

Current CalOptima Contract

- Current updated Medi-Cal contract language clarifies DHCS position:
  - Exhibit A, Attachment 6 (Provider Network), Provision 12 (Subcontracts)

    "Contractor shall remain accountable for all functions and responsibilities that are delegated to subcontractors. Nothing in this provision shall be construed to require that subcontracting providers be enrolled as a Medi-Cal provider."

Issue

- What should the policy be in those cases where compliance with both requirements are in conflict, specifically when access and quality cannot be met within a Medi-Cal enrolled network?
  - CalOptima has an informal process that is based on medical necessity
  - The informal “exception” policy is not consistent with the current participation policy

Exceptions

- Geographic
  - Availability of service in geographic area
- Clinical service
  - Access to the most appropriate level of experience available
- Continuity of care
  - Maintaining on-going treatment plan
- Member specific need that can drive clinical outcomes
  - Culture
  - Religion
  - Gender

Analysis 2009

- COD Prior Authorization = 30,000

- Letters of Agreement = 906
  - Ambulatory Surgery Centers = 591
  - Hospitals = 197
  - Other Facilities = 50
  - Professional Services = 56
  - Other = 12

Analysis 2009

- Historical (Non Medi-Cal enrolled providers)
  - ➢COD (Registered) = 163 of 4,647 total contracted providers = 3.5%
  - ➢Noble = 9 of 369 total contracted providers = 2.4%
  - ➢CHOC Health Alliance = 6 of 688 total contracted providers = 0.9%
  - ➢Monarch = 72 of 1,532 total contracted providers = 4%

Risk

- CalOptima would have to assume legal and enforcement functions without the State's police powers for those non- Medi-Cal enrolled providers, just as with all other lines of business

- Poses minimum risk because:
  1. Credentialing process
  2. Primary focus is high complex specialty directed providers who have affiliations with tertiary facilities
  3. Low utilization of exceptions
  4. CalOptima oversight activities including both compliance and peer review

Recommendation

Align the informal process with current policy to continue Medi-Cal participation with exceptions that promote access and quality based on medical necessity review.

CalOptima's Mission

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

Policy #:	GG.1304
Title:	**Continuity of Care During Health Network or Provider Termination**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader MS
Effective Date:	02/04/03
Last Review Date:	10/01/18
Last Revised Date:	10/01/18

I. PURPOSE

This policy establishes coverage and continuity of care guidelines for a Member who is involuntarily required to change a Health Network or Provider.

II. POLICY

A. CalOptima or a Health Network shall ensure Continuity of Care for a Member.

B. CalOptima may require a Member to change his or her Health Network involuntarily due to special circumstances including, but not limited to, the termination or non-renewal of the Health Network's Contract for Health Care Services.

C. A Receiving Health Network shall assume full responsibility for a Member's care upon the Affected Member's effective date with the Receiving Health Network when the Member is involuntarily required to change Health Networks.

D. In the event of section II.B of this Policy, CalOptima shall ensure the provision of Covered Services to an Affected Member without disruption or delay, including, but not limited to:

1. A Member who is in an active treatment plan;

2. A Member who has medical supply or other needs that affect the Member's quality of life or activities of daily living;

3. A Member who is in the process of evaluation for certain services; and

4. A Member who has other medical care needs.

E. In the event that a Member is required to change Health Networks, CalOptima and the Receiving Health Network shall collaborate to coordinate the provision of Covered Services for the Affected Member.

F. To ensure that inappropriate disruptions or delays in Covered Services do not occur during an Affected Member's transition to a Receiving Health Network, CalOptima and the Receiving Health Network shall make Continuity of Care decisions, in accordance with the guidelines set forth in this Policy and based on the potential best medical outcome for the Affected Member.

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G. In the event that the guidelines set forth in this Policy do not address an Affected Member's particular continuity of care circumstance or need during the Affected Member's transition from a Health Network, CalOptima's Chief Medical Officer (CMO), or his or her Designee, shall render final arbitration of a Health Network's decision regarding the authorization of Covered Services.

H. To ensure the Continuity of Care for an Affected Member, a Receiving Health Network shall coordinate the Affected Member's Covered Services and the payment of Covered Services to a Provider when the prior Health Network authorized the Affected Member's care with the existing Provider and there is an existing course of treatment. The Receiving Health Network shall reimburse a Non-Contracted Provider in accordance with the provisions of this Policy.

I. A Receiving Health Network shall notify an Affected Member of its decision to approve, modify, delay, or deny a request for authorization of Continuity of Care, in accordance with the guidelines set forth in CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

J. CalOptima or a Health Network may require a Member to change his or her Provider involuntarily due to special circumstances including, but not limited to, suspensions, decertifications, or non-renewal of a Health Network or Provider's contract with CalOptima or a Health Network, including termination, suspensions, and decertifications from the Medi-Cal program as effectuated by DHCS.

1. CalOptima or a Health Network shall ensure the safe transition to a new Provider for services as necessary and in accordance with this Policy.

K. Health Networks shall notify CalOptima of Provider termination, in accordance with CalOptima Policies DD.2012: Member Notification of Change in Availability or Location of Covered Services, EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

III. PROCEDURE

A. Identification of an Affected Member and the Affected Member's Needs

1. CalOptima shall work in collaboration with the terminating Health Network to ensure identification of an Affected Member who is involuntarily required to change Health Networks and identify those Members who are in need of care coordination of Covered Services within a Health Network.

2. CalOptima shall provide a Receiving Health Network with information about an Affected Member's Continuity of Care needs as the information becomes available.

3. A Receiving Health Network shall evaluate an Affected Member's need for Covered Services and may authorize appropriate Covered Services for the Affected Member in a timely manner in order to not delay or interrupt the Affected Member's active treatment plan, in accordance with the provisions of this Policy.

B. Notice to Affected Members of Health Network termination

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1. CalOptima shall send written notice of Health Network termination to Affected Members no later than thirty (30) calendar days prior to the termination date of a Health Network Contract for Health Care Services.

2. CalOptima shall obtain approval from the Department of Health Care Services (DHCS) of the written notice prior to sending the notice of Health Network termination to Affected Members.

C. CalOptima and a Health Network shall use the following Continuity of Care guidelines to provide continued Covered Services to an Affected Member so as to not cause an interruption or delay for the Affected Member:

1. A Receiving Health Network shall honor an authorization for a Scheduled Elective Surgery for an Affected Member authorized by the terminating Health Network, unless the Receiving Health Network is able to arrange comparable services without delay or interruption to the Affected Member, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

2. A Receiving Health Network shall allow an Affected Member who is in the course of oncology treatment to continue his or her course of treatment with the Affected Member's existing Provider as set forth below:

   a. The Receiving Health Network shall evaluate an Affected Member's oncology treatment plan and determine whether it is appropriate to transfer the Affected Member's oncology care services safely to another Provider without delay or interruption to the active treatment plan.

   b. If the Receiving Health Network determines that transferring the Affected Member's oncology care to another Provider may potentially result in an adverse medical outcome or detrimentally affect the Affected Member, the Receiving Health Network shall authorize the Affected Member's oncology services under the Affected Member's existing Provider until the active treatment plan is completed.

3. A Receiving Health Network shall allow an Affected Member, who is in the process of a transplant evaluation to complete transplant care services with the Affected Member's existing Provider. Transplant coordination of care for an Affected Member shall be managed, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

4. A Receiving Health Network shall allow an Affected Member, who is receiving acute inpatient services on the effective date of the Receiving Health Network change and is expected to have a remaining length of stay less than or equal to three (3) calendar days, to continue his or her acute care stay in the current inpatient setting.

5. A Receiving Health Network shall authorize an Affected Member, who has a remaining length of stay in an acute inpatient setting of more than three (3) calendar days, to stay in the existing acute inpatient setting until the Receiving Health Network can arrange for the safe transfer of the Affected Member to another acute care facility that can provide comparable services.

6. If it is necessary for an Affected Member to reschedule post-surgical physician visits after the effective date of the Receiving Health Network change, the Receiving Health Network shall

authorize the Affected Member's remaining post-surgical visits which were included under a previous global authorization with the surgeon who performed the surgery pursuant to community standards and Medical Necessity.

7. A Receiving Health Network shall authorize continued obstetrical services for an Affected Member, including delivery and the immediate postpartum period, with the Affected Member's existing Provider and hospital if the Affected Member is in her second (2nd) or third (3rd) trimester of pregnancy.

8. If an Affected Member is receiving dialysis services, a Receiving Health Network shall authorize continued dialysis services with the Affected Member's existing dialysis center and nephrologist until the Receiving Health Network has evaluated the Affected Member's dialysis treatment plan and arranged for the Affected Member's safe transfer to another dialysis center or nephrologist without a delay or interruption in service.

9. If an Affected Member has a scheduled diagnostic and Ancillary Service on a date after the Affected Member's effective date of the Health Network change, the Receiving Health Network shall authorize the diagnostic or Ancillary Service with the previously scheduled Provider unless the Receiving Health Network is able to arrange comparable services with another Provider without a delay or interruption in service.

10. If an Affected Member receives injectables as part of an active treatment plan, a Receiving Health Network shall ensure that the prescribed injectables are continued without delay or interruption in accordance with the Affected Member's active treatment plan until the Receiving Health Network has re-evaluated the Affected Member's active treatment plan, including potential referrals and coordination with California Children's Services (CCS).

11. If an Affected Member receives long term acute care services, a Receiving Health Network shall authorize the long term care acute care services at the Affected Member's existing facility until the Receiving Health Network has re-evaluated the Affected Member and provides for the safe transfer of the Affected Member's care to an alternate facility, with consideration of family or guardian wishes.

12. A Health Network that authorizes the purchase of Durable Medical Equipment (DME) for an Affected Member shall pay for the cost of the DME even if the delivery of the DME occurs after the Affected Member's effective date of the Health Network change.

13. A Receiving Health Network shall continue to provide an Affected Member with the same medical supplies, quantities, or equipment without disruption or delay in services until the Receiving Health Network has evaluated the Affected Member's medical supply needs.

14. If, after consultation with the CalOptima CMO, or his or her Designee, the CMO determines certain services are required and the Receiving Health Network refuses to provide them, the CMO may authorize these services on behalf of the Receiving Health Network.

15. If a Receiving Health Network modifies, delays, denies, or takes any other action that triggers Aid Paid Pending an appeal, the Receiving Health Network shall follow Member notification requirements and related provisions, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

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16. If CalOptima or a Health Network requires a Member to change his or her Provider involuntarily due to suspensions, decertifications, or non-renewal of a Health Network or Provider's contract with CalOptima or a Health Network, including termination, suspensions, and decertifications from the Medi-Cal program as effectuated by DHCS, CalOptima or a Health Network shall coordinate with the receiving Provider for ongoing services and treatment.

    a. CalOptima or a Health Network shall ensure the terminated, suspended, or decertified Provider does not receive payment for Medi-Cal services provided on or after the effective date of action in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

    b. CalOptima or a Health Network shall communicate the notification to the affected Member in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

17. A Receiving Health Network shall pay for the Covered Services furnished to an Affected Member by the Affected Member's existing Provider as authorized by the terminating Health Network to maintain Continuity of Care in accordance with this Policy. The Receiving Health Network shall pay a Non-Contracted Provider for such items and services at the Medi-Cal Fee Schedule rate or, if inpatient services, at the CalOptima rate.

D. CalOptima may impose Sanctions on a Health Network, including and without limitation, financial penalties or termination, in accordance with CalOptima Policy HH.2002Δ: Sanctions, when the Health Network fails to comply with the requirements of this Policy.

E. CalOptima or a Health Network shall notify an Affected Member of Provider termination, in accordance with CalOptima Policy DD.2012: Member Notification of Change in Availability or Location of Covered Services.

F. CalOptima or a Health Network shall provide continued Covered Services to an Affected Member so as to not cause an interruption or delay using the following continuity of care guidelines:

    1. CalOptima or a Health Network shall ensure continuation of treatment through the current period of active treatment, not to exceed twelve (12) months .

    2. CalOptima or a Health Network shall ensure continuation of care through the postpartum period for a Member in their second (2nd) or third (3rd) trimester of pregnancy.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal

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C. CalOptima Policy DD.2012: Member Notification of Change in Availability or Location of Covered Services
D. CalOptima Policy EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory
E. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
F. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
G. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
H. CalOptima Policy HH.2002Δ: Sanctions
I. 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
J. Department of Health Care Services All Plan Letter (APL) 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications

VI. REGULATORY APPROVALS

A. 01/31/18: Department of Health Care Services
B. 10/14/15: Department of Health Care Services
C. 09/11/13: Department of Health Care Services
D. 11/10/09: Department of Health Care Services

VII. BOARD ACTIONS

A. 02/04/03: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/04/2003	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2007	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2010	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2012	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2013	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Reviewed	07/01/2014	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	07/01/2015	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2016	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2017	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	10/01/2018	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal

IX. GLOSSARY

Term	Definition
Affected Member	A Member who is involuntarily transitioning between Health Networks or Providers due to circumstances that include, but are not limited to the termination or non-renewal of a Health Network Contract.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a notice of action of intent to terminate, suspend, or reduce an existing authorized service.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Continuity of Care	Services provided to a Member rendered by an out-of-network Provider with whom the Member has a pre-existing Provider relationship.
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.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME)	Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. For purposes of this policy, a Health Network shall include CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

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Term	Definition
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima, a Physician Medical Group, or a Health Network.
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.
Receiving Health Network	A Health Network to which a Member is transitioning.
Scheduled Elective Surgery	Non-urgent or non-emergent procedures to treat disease, injury, or deformity by physical operation or manipulation, which are requested by the treating physician and authorized by the Health Network to occur within sixty (60) days after transitioning to the Receiving Health Network.

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Policy #:	EE.1141Δ
Title:	**CalOptima Provider Contracts**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	*/s/ Michael Schrader 07/17/2019*
Effective Date:	02/01/2017
Revised Date:	04/04/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

Board Approved Policy

I. PURPOSE

This policy details the process by which CalOptima contracts with **Providers***, or establishes **Letters of Agreement (LOAs),** as appropriate, with out-of-network **Providers** to meet its State and Federal obligations regarding **Network** adequacy and **Continuity of Care.**

II. POLICY

A. CalOptima may enter into a contract for participation directly with a **Provider** to ensure access to **Covered Services** for **Members**, and to obtain cost-effective pricing for **Covered Services**.

B. CalOptima may contract with **Providers** that meet the participation requirements for applicable health care programs and are fully **Credentialed** by CalOptima in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners and GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations.

C. As a condition of participation in the CalOptima Medi-Cal program, contracting **Providers** shall be enrolled in the State's Medi-Cal Program in accordance with requirements set forth by the **Department of Health Care Services (DHCS).** When enrollment in the State's Medi-Cal program is not available to the **Provider's** provider type, contracting **Providers** shall be subject to CalOptima's enrollment and screening process.

D. As a condition of participation in the CalOptima OneCare and OneCare Connect programs, **Providers** shall not be excluded/sanctioned from participation in Medicare, shall not have opted out of Medicare, and shall not be listed on CMS' **Preclusion List.**

E. As a condition of participation in the CalOptima Program of All-Inclusive Care for the Elderly (PACE) program, contracting health care **Providers** shall be enrolled in the State's Medi-Cal Program in accordance with requirements set forth by the **DHCS.**

F. CalOptima shall determine **Network** adequacy by health care program and contract with those **Provider** types needed to, at a minimum, maintain an adequate **Network** as described in the requirement of each program.

G. CalOptima shall use provider contract templates as approved by the CalOptima Legal Affairs Department and the **DHCS** based on **Provider** type. If necessary, CalOptima may negotiate services at a rate that is not to exceed levels approved by the CalOptima Board of Directors.

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

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1. CalOptima's Contracting Department shall obtain written approval from the CalOptima Chief Executive Officer (CEO) or his **Designee** for any rate that exceeds the CalOptima Board of Directors approved level.

2. Upon the recommendation of the CalOptima Chief Medical Officer (CMO), the CEO, or his **Designee** may negotiate rates and payment terms with **Providers** for **Medically Necessary, Covered Services** in unique situations, where contracted **Providers** or **Providers** that are willing to enter into standard **LOAs** are not qualified to provide the necessary services.

3. With Board approval, the CEO may implement new rate methodologies for Medi-Cal Fee-For-Service contracted hospitals, including but not limited to, tiered per diems, All Patient Refined Diagnosis Related Group (APR-DRG) based reimbursement, case rates, and blended per diem rates.

F. CalOptima shall execute a **Letter of Agreement (LOA)** with an out-of-network **Provider** where **Medically Necessary, Covered Services** to a **Member** are required:

a. In order to access care not available through contracted **Providers** and where the **Providers** of the necessary services do not accept CalOptima's out-of-network rates; or

b. For **Continuity of Care** needs where the **Provider** will accept CalOptima's standard rates, but does not wish to be a regularly-contracted CalOptima **Provider**; or

c. For **Continuity of Care** needs when the **Provider** will not accept CalOptima's standard rates, but transitioning the care to a contracted **Provider**:

i. Would require the **Member** to receive services from multiple **Providers**/facilities in an uncoordinated manner which would significantly impact the **Member's** condition; or

ii. Could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment.

iii. Would require **Member** to undertake a substantial change in recommended treatment for **Medically Necessary, Covered Services**.

III. PROCEDURE

A. Preliminary Evaluation

1. If CalOptima determines there is an unmet **Provider** coverage need which causes **Member** access issues and/or unmet **Continuity of Care** obligations, Contracting Department shall reach out to **Providers** identified through claims paid data, **LOAs**, or **Member** requests and invite them to enter into a contract for **Covered Services**. Contracted provider **Network** adequacy will be reviewed on an ongoing basis.

2. **Providers** that wish to proceed with a contract for participation in CalOptima's Medi-Cal program must be actively enrolled with Medi-Cal, with the exception of **Provider** types that do not have an enrollment pathway through the State. The CalOptima Quality Improvement Department shall perform a supplemental internal screening for Provider types that do not have an enrollment pathway through the State when processing their **Credentialing** applications.

3. **Physicians** shall be required to meet the minimum physician standards as described in CalOptima Policy GG.1643: Minimum Physician Standards, and must complete a

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Credentialing application. The CalOptima Quality Improvement Department shall review and approve or deny the **Credentialing** application in accordance with CalOptima Policies GG.1643: Minimum Physician Standards and GG.1650Δ: Credentialing and Recredentialing of Practitioners.

4. **Health Delivery Organizations (HDOs)** shall be required to complete a **Credentialing** application. The CalOptima Quality Improvement Department shall review and approve or deny the **Credentialing** application in accordance with CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations.

5. The Quality Improvement Department shall notify the Contracting and Provider Relations Departments when a **Provider** has passed or been denied **Credentialing**. If CalOptima denies **Credentialing**:

    a. Contracting shall notify the **Provider** that CalOptima will not be able to contract with the **Provider**.

    b. If **Credentialing** has been denied for a physician who is part of a contracted physician group, the Provider Relations Department shall notify the contracted physician group that CalOptima will not be able to include the physician under the group contract.

B. Contract Completion

1. Upon receipt of an approval of **Credentialing** from the Quality Improvement Department, the contract shall be completed as follows:

    a. If applicable, the Contracting Department shall negotiate rates with the **Provider** within limits set by the CalOptima Board of Directors, in accordance with Section II.G of this Policy.

    b. Contract will be signed by the **Provider**.

    c. Contracting Department shall route a **Provider**-signed contract to the appropriate signer for counter-signature in accordance with the CalOptima Policy GA.3202: Signature Authority.

    d. Once the contract is fully executed, the Contracting Department shall complete and forward a Contract Summary form to internal departments, as applicable.

    e. Contracting shall assign the effective date as the first day of the month following the signature of both parties, unless:

        i. An effective date is specified in an applicable CalOptima Board Action Agenda Referral (COBAR); or

        ii. Additional time is required for information systems programming.

    f. If a newly **Credentialed** physician is part of an existing contracted physician group, the Provider Relations Department shall assign the effective date as the first day of the month following approval notification from the Quality Improvement Department. The Provider Relations Department shall notify Provider Data Management Services to enter the physician into the FACETS system.

2. The Contracting Department shall notify the **Provider** of contract completion and forward the fully executed contract to the **Provider**.

C. **Letter of Agreement (LOA)**

1. CalOptima shall provide **Medically Necessary, Covered Services** to a Member through an out-of-network **Provider** when CalOptima is unable to provide services in the contracted **Network** in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals, or when it is necessary for purposes of **Continuity of Care**.

2. CalOptima shall generate an **LOA** for all Medi-Cal out-of-network long-term care facilities, Medi-Cal hospitals, physicians, ancillary, or other entities as necessary, and all out-of-network OneCare Connect **Providers**.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicaid & Medicare Services (CMS) for OneCare
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima PACE Program Agreement
D. CalOptima Policy EE.1135: Long Term Care Facility Contracting
E. CalOptima Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Policy GG.1643Δ: Minimum Physician Standards
G. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
H. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
I. CalOptima Three-way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-019: Provider Credentialing/Recredentialing and Screening/Enrollment

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2007	Regular Meeting of the CalOptima Board of Directors
06/04/2009	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
04/04/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2017	EE.1141Δ	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	EE.1141Δ	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	04/04/2019	EE.1141Δ	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	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.
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 Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Health Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.

Term	Definition
Medically Necessary	Medi-Cal: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. OneCare: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. OneCare Connect: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5. PACE: 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.
Network	Primary Care Providers, Specialists, hospitals, pharmacy, ancillary Providers, facilities, and any other Providers that subcontract with CalOptima for the delivery of Covered Services.
Preclusion List	CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
Provider	Any individual or entity that is engaged in the delivery of Covered Services, or ordering or referring for the Covered Services, and is licensed or certified to do so.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Approval of OneCare and OneCare Connect Polices related to Direct Member Reimbursement for Covered Services

Contact

Belinda Abeyta, Executive Director, Operations Management (714) 246-8400

Recommended Action(s)

Approve the following new Policies and Procedures related to OneCare and OneCare Connect:

1. MA.4016: Direct Member Reimbursement for Covered Services

2. CMC.4012: Direct Member Reimbursement for Covered Services

Background/ Discussion

Periodically, CalOptima establishes new or modifies existing Policies and Procedures to implement new or modified, laws, regulatory guidance, contracts, business practices and benefits. CalOptima has an annual policy review process by which Policies and Procedures are updated and implemented to comply with new laws, regulations, guidelines or programs as required.

The following new policies related to Direct Member Reimbursement have been reviewed and approved by CalOptima's Policy and Procedure Review Committee and are being presented for review and approval by the Board of Directors:

1. ***MA.4016: Direct Member Reimbursement for Covered Services*** outlines the circumstances and requirements under which CalOptima, or a Health Network, may directly reimburse a OneCare member for out-of-pocket costs that exceed any Member cost-sharing obligations incurred for covered services, including, with an annual reimbursement cap, emergency and urgent services received from providers outside of the United States upon completion of a coverage decision.

2. ***CMC.4012: Direct Member Reimbursement for Covered Services*** outlines the circumstances and requirements under which CalOptima, or a Health Network, may directly reimburse a OneCare Connect member for out-of-pocket costs that exceed any Member cost-sharing obligations incurred for covered services, including, with an annual reimbursement cap, emergency and urgent services received from providers outside of the United States upon completion of a coverage decision.

Fiscal Impact

The recommended action to approve CalOptima Policies MA.4016 and CMC.4012 for OneCare and OneCare Connect Direct Member Reimbursement for Covered Services is a budgeted item and was included in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget that was approved by the Board on June 6, 2019. The annual estimated cost for this benefit is approximately $7,000 for OneCare and $66,000 for OneCare Connect. However, the actual cost may vary year to year and may be greatly impacted by variables, such as amount of travel and the number of catastrophic cases.

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Rationale for Recommendation

To ensure CalOptima and Health Networks meet all requirements of the OneCare program, approval of the requested action is recommended.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. MA.4016: Direct Member Reimbursement for Covered Services
2. CMC.4012: Direct Member Reimbursement for Covered Services

/s/ Michael Schrader *11/26/2019*

Authorized Signature **Date**

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Policy:	MA.4016PP
Title:	**Direct Member Reimbursement for Covered Services**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	12/05/2019
Revised Date:	Not Applicable

FOR 20191205BOD REVIEW

I. PURPOSE

This policy outlines the circumstances and requirements under which CalOptima or a **Health Network** may directly reimburse a OneCare **Member** for covered health care expenses rendered by a **Provider** upon completion of a coverage decision.

II. POLICY

A. A **Provider** shall bill CalOptima or the **Health Network**, as appropriate, for services rendered to a OneCare **Member**.

B. CalOptima OneCare **Members** retain the right to be reimbursed by CalOptima or a **Health Network** for any bill(s) paid in excess of the **Member's** cost sharing amount for **Covered Services**.

C. CalOptima or a **Health Network** shall directly reimburse a **Member** for a **Covered Service** if the **Member** was actively enrolled in OneCare, on the date of service (DOS), and has incurred the payment of the bill, in whole, or in part.

D. A **Health Network** shall reimburse a OneCare **Member** for a **Covered Service** if the **Member** was eligible with the CalOptima contracted **Health Network** on the DOS.

E. CalOptima shall process reimbursements to **Members** for prescription drugs in accordance with CalOptima Policy MA.6101: Coverage Determination.

F. In accordance with CalOptima policy, a OneCare **Member** shall directly request reimbursement any time after the date the health care service(s) was rendered.

1. If a OneCare **Member** does not request reimbursement, the OneCare **Member** shall be responsible for payment of the bill(s), with the following exception:

    a. There is a change to the OneCare benefits, pursuant to the Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS).

G. CalOptima or a **Health Network** shall deny a Direct Member Reimbursement (DMR) request if the **Member** or **Provider** did not comply with the **Prior Authorization** requirements outlined in CalOptima Policies GG.1508: Authorization and Processing of Referrals and GG.1539: Authorization for Out-of-Network and Out-of-Area Services, as applicable.

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H. If the OneCare **Member** has not yet paid a bill or invoice submitted to CalOptima or a **Health Network** and CalOptima's or a **Health Network** determines that the service being billed is CalOptima's or a **Health Network's** financial responsibility, CalOptima or a **Health Network** shall directly pay the **Provider** for the service.

III. PROCEDURE

A. Direct Member Reimbursement

1. Within sixty (60) calendar days from receiving a OneCare **Member's** request for reimbursement, CalOptima or a **Health Network** shall directly reimburse a OneCare **Member** subject to the requirements of this Policy, when the OneCare **Member** directly paid out of pocket for **Covered Services** in the following circumstances:

    a. **Emergency or Urgent Services** received from an out-of-network **Provider** or out-of-area **Provider**;

        i. Maximum member reimbursement supplemental benefit amount per benefit year for **Emergency or Urgent Services** received outside of the United States as a supplemental covered benefit.

    b. The payment made by the OneCare **Member** exceeded their cost sharing amount;

    c. For a date of service that occurred during the **Member's** retroactive enrollment with CalOptima OneCare;

    d. For prescription refills using an in-network or out-of-network pharmacy;

    e. For the full cost of a prescription due to inability to provide proof of eligibility (e.g., not providing the CalOptima membership card); and/or

    f. For the full cost of a **Covered Service** or covered drug in other situations.

2. For **Covered Services**, a OneCare **Member** shall mail, fax, or email the reimbursement request to CalOptima, or a **Health Network,** based on Division of Financial Responsibility.

3. All OneCare direct member reimbursement (DMR) requests shall include:

    a. Proof of payment (a copy of the credit card charge slip(s) or online statement, canceled checks, a bank account statement, cash withdrawal slips, or a cruise ship statement); and

    b. Copy of itemized bill showing all services received. The bill must include the **Member's** name, address, phone number, tax ID of doctor and/or facility, and all diagnosis and procedure codes, if available; and

    c. **Member** written request to be reimbursed; and

    d. Discharge summary or equivalent medical documentation; and

    e. Authorization of Representative Form (CMS-1696) or equivalent notice, if applicable.

4. CalOptima, or a **Health Network**, shall review the OneCare **Member's** reimbursement request and make a coverage decision.

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5. CalOptima, or a **Health Network**, shall outreach to the OneCare **Member** or **Provider** if additional information is necessary to make a determination for the reimbursement request.

6. CalOptima, or a **Health Network,** shall reimburse the OneCare **Member** for the **Covered Service** paid, if:

    a. Authorization is required, all authorization policies and procedures were complied with when obtaining the **Covered Services**; and

    b. The **Covered Services** rendered were deemed medically necessary after conclusion of CalOptima or a **Health Network's** Utilization Management departments medical review, as applicable; and

    c. Any payment made directly by a share of cost where the OneCare **Member** exceeded their share of cost; and

    d. The services paid for is a covered benefit under the OneCare program.

7. CalOptima, or a **Health Network,** shall not reimburse the OneCare **Member** for the service(s), paid if:

    a. The **Member** was ineligible with CalOptima or a **Health Network** on the DOS for which the reimbursement is being requested; or

    b. A **Prior Authorization** was required for the service but not obtained in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals; or

    c. The **Member** received out-of-network non-emergency services and did not adhere to CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services; or

    d. The service(s) rendered were deemed medically unnecessary after medical review conducted by CalOptima or a **Health Network's** Utilization Management department; or

    e. The payment made by the OneCare **Member** did not exceed their share of cost; or

    f. The service obtained is not a covered benefit.

8. Within sixty (60) calendar days from receiving a OneCare **Member** request for reimbursement, if CalOptima or a **Health Network** denies a OneCare **Member's** reimbursement request, CalOptima or a **Health Network** shall provide a written and telephonic notice to the **Member** of the following information:

    a. A detailed explanation of the reason(s) for the denial;

    b. An explanation of the OneCare **Member's** financial responsibility; and

    c. The OneCare **Member's** right to appeal CalOptima's or a **Health Network's** decision.

9. A OneCare **Member** shall have a right to appeal CalOptima's or a **Health Network's** decision for the reimbursement request, in accordance with CalOptima Policies MA.9003: Standard Appeal and MA.9005: Payment Appeal.

FOR 20191205BOD REVIEW

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy GG.1508: Authorization and Processing of Referrals
C. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
D. CalOptima Policy MA.4008: Evidence of Coverage
E. CalOptima Policy MA.9003: Standard Appeal
F. CalOptima Policy MA.9005: Payment Appeal
G. CalOptima Policy MA.6101: Coverage Determination
H. Medicare Prescription Drug Benefit Manual, Section 50.4.3
I. Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections
J. Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 40.10
K. Title 42, Code of Federal Regulations §422.520

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/05/2019	MA.4016PP	Direct Member Reimbursement	OneCare

FOR 20191205BOD REVIEW

IX. GLOSSARY

Term	Definition
Covered Service	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way contract with the Department of Healthcare Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS).
Covered Part D Drug	A Covered Part D Drug includes: 1. A drug that may be dispensed only upon a Prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication as set forth in Section 1927(k)(2)(A) of the Social Security Act; 2. A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Social Security Act; 3. Insulin described in section 1927(k)(2)(C) of the Social Security Act; 4. Medical supplies associated with the delivery of insulin; and 5. A vaccine licensed under section 351 of the Public Health Service Act and its administration.
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of OneCare program.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	A physician, 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.
Supporting Documentation	Bill, discharge summary or equivalent medical documentation, and proof of payment. Member written request to be reimbursed.

FOR 2019 1205 BOD REVIEW

Term	Definition
Urgent Care	Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations: 1. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment; or 2. In the opinion of a Practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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Policy:	CMC.4012PP
Title:	**Direct Member Reimbursement for Covered Services**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	12/05/2019
Revised Date:	Not Applicable

FOR 2019 12 05 BOD REVIEW

I. PURPOSE

This policy outlines the circumstances and requirements under which CalOptima or a **Health Network** may directly reimburse a OneCare Connect **Member** for covered health care expenses rendered by a **Provider** upon completion of a coverage decision.

II. POLICY

A. A **Provider** shall bill CalOptima or the **Health Network**, as appropriate, for services rendered to a OneCare Connect **Member**.

B. CalOptima OneCare Connect **Members** retain the right to be reimbursed by CalOptima or a **Health Network** for any bill(s) paid in excess of the **Member's** cost sharing amount for **Covered Services**.

C. CalOptima or a **Health Network** shall directly reimburse a **Member** for a **Covered Service** if the **Member** was actively enrolled in OneCare Connect, on the date of service (DOS), and has incurred the payment of the bill, in whole, or in part.

D. A **Health Network** shall reimburse a OneCare Connect **Member** for a **Covered Service** if the **Member** was eligible with the CalOptima contracted **Health Network** on the DOS.

E. CalOptima shall process reimbursements to **Members** for prescription drugs in accordance with CalOptima Policy MA.6101: Coverage Determination.

F. In accordance with CalOptima policy, a OneCare Connect **Member** shall directly request reimbursement any time after the date the health care service(s) was rendered.

1. If a OneCare Connect **Member** does not request reimbursement, the OneCare Connect **Member** shall be responsible for payment of the bill(s), with the following exception:

    a. There is a change to the OneCare Connect benefits, pursuant to the Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS).

G. CalOptima or a **Health Network** shall deny a direct member reimbursement (DMR) request if the **Member** or **Provider** did not comply with the **Prior Authorization** requirements outlined in CalOptima Policies GG.1508: Authorization and Processing of Referrals and GG.1539: Authorization for Out-of-Network and Out-of-Area Services, as applicable.

H. If the OneCare Connect **Member** has not yet paid a bill or invoice submitted to CalOptima or a **Health Network** and CalOptima or a **Health Network** determines that the service being billed is

CalOptima's or a **Health Network's** financial responsibility, CalOptima or a **Health Network** shall directly pay the **Provider** for the service.

III. PROCEDURE

A. Direct Member Reimbursement

1. Within sixty (60) calendar days from receiving a OneCare Connect **Member's** request for reimbursement, CalOptima or a **Health Network** shall directly reimburse a OneCare Connect **Member** subject to the requirements of this Policy, when the OneCare Connect **Member** directly paid out of pocket for **Covered Services** in the following circumstances:

   a. **Emergency or Urgent Services** received from an out-of-network **Provider** or out-of-area **Provider**;

      i. Maximum member reimbursement supplemental benefit amount per benefit year for **Emergency or Urgent Services** received outside of the United States as a supplemental covered benefit.

   b. The payment made by the OneCare Connect **Member** exceeded their cost sharing amount;

   c. For a date of service that occurred during the **Member's** retroactive enrollment with CalOptima OneCare Connect;

   d. For prescription refills using an in-network or out-of-network pharmacy;

   e. For the full cost of a prescription due to inability to provide proof of eligibility (*e.g.*, not providing the CalOptima membership card); and/or

   f. For the full cost of a **Covered Service** or covered drug in other situations.

2. For **Covered Services**, a OneCare Connect **Member** shall mail, fax, or email the reimbursement request to CalOptima or a **Health Network** based on Division of Financial Responsibility.

3. All OneCare Connect direct member reimbursement (DMR) requests shall include:

   a. Proof of payment (a copy of the credit card charge slip(s) or online statement, canceled checks, a bank account statement, cash withdrawal slips, or a cruise ship statement); and

   b. Copy of itemized bill showing all services received. The bill must include the **Member's** name, address, phone number, tax ID of doctor and/or facility, and all diagnosis and procedure codes, if available; and

   c. **Member** written request to be reimbursed; and

   d. Discharge summary or equivalent medical documentation; and

   e. Authorization of Representative Form (CMS-1696) or equivalent notice, if applicable.

4. CalOptima, or a **Health Network,** shall review the OneCare Connect **Member's** reimbursement request and make a coverage decision.

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5. CalOptima, or a **Health Network,** shall outreach to the OneCare Connect **Member** or **Provider** if additional information is necessary to make a determination for the reimbursement request.

6. CalOptima, or a **Health Network,** shall reimburse the OneCare Connect **Member** for the **Covered Service** paid if:

    a. Authorization is required, all authorization policies and procedures were complied with when obtaining the **Covered Services**; and

    b. The **Covered Services** rendered were deemed medically necessary after conclusion of CalOptima or a **Health Network's** Utilization Management departments medical review, as applicable; and

    c. Any payment made directly by a share of cost where the OneCare Connect **Member** exceeded their share of cost; and

    d. The services paid for is a covered benefit under the OneCare Connect program.

7. CalOptima or a **Health Network** shall not reimburse the OneCare Connect **Member** for the service(s) paid if:

    a. The **Member** was ineligible with CalOptima or a **Health Network** on the DOS for which the reimbursement is being requested; or

    b. A **Prior Authorization** was required for the service but not obtained in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals; or

    c. The **Member** received out-of-network non-emergency services and did not adhere to CalOptima's Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services; or

    d. The service(s) rendered were deemed medically unnecessary after medical review conducted by CalOptima or a **Health Network's** Utilization Management department; or

    e. The payment made by the OneCare Connect **Member** did not exceed their share of cost; or

    f. The service obtained is not a covered benefit.

8. Within sixty (60) calendar days from receiving a OneCare Connect **Member** request for reimbursement, if CalOptima or a **Health Network** denies a OneCare Connect **Member's** reimbursement request, CalOptima or a **Health Network** shall provide a written and telephonic notice to the **Member** of the following information:

    a. A detailed explanation of the reason(s) for the denial;

    b. An explanation of the OneCare Connect **Member's** financial responsibility; and

    c. The OneCare Connect **Member's** right to appeal CalOptima's or a **Health Network's** decision.

9. A OneCare Connect **Member** shall have a right to appeal CalOptima's or a **Health Network's** decision for the reimbursement request, in accordance with CalOptima Policies CMC.9003: Standard Appeal and CMC.9005: Payment Appeal.

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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Policy CMC.9003: Standard Appeal
B. CalOptima Policy CMC.9005: Payment Appeal
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
E. CalOptima Policy MA.6101: Coverage Determination
F. CalOptima Policy CMC.1001: Glossary of Terms
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Medicare Prescription Drug Benefit Manual, Section 50.4.3
I. Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections
J. Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 40.10
K. Title 42, Code of Federal Regulations, §422.520

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/05/2019	CMC.4012PP	Direct Member Reimbursement	OneCare Connect

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IX. GLOSSARY

Term	Definition
Covered Service	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way contract with the Department of Healthcare Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS).
Covered Part D Drug	A Covered Part D Drug includes: 1. A drug that may be dispensed only upon a Prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication as set forth in Section 1927(k)(2)(A) of the Social Security Act; 2. A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Social Security Act; 3. Insulin described in section 1927(k)(2)(C) of the Social Security Act; 4. Medical supplies associated with the delivery of insulin; and 5. A vaccine licensed under section 351 of the Public Health Service Act and its administration.
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that Health Network.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of OneCare Connect program.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	A physician, 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.
Supporting Documentation	Bill, discharge summary or equivalent medical documentation, and proof of payment. Member written request to be reimbursed.

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Term	Definition
Urgent Care	Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations: 1. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment; or 2. In the opinion of a Practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
9. Consider Approval of Revisions to the Medi-Cal Palliative Care Services Policy

Contact
Tracy Hitzeman, RN, CCM Executive Director Clinical Operations (714) 246-8400

Recommended Action(s)
Approve revisions to CalOptima Policy GG.1550: Palliative Care Services.

Background
Medi-Cal managed care health plans (MCPs) are required to provide palliative care to their members pursuant to Senate Bill (SB) 1004 (Hernandez, Chapter 574, Statutes of 2014). This applies to Medi-Cal managed care members who are not dually eligible for Medicare and Medi-Cal.

Following the October 2017 release of the California Department of Health Care Services (DHCS) APL 17-015: Palliative Care and Medi-Cal Managed Care, CalOptima developed Policy GG.1550 Palliative Care Services. The policy provided for these services without age limitation. The policy was approved by CalOptima's Board of Directors on December 7, 2017.

However, as Pediatric Palliative Care (PPC) was also at that time provided as a Home and Community–Based Services (HCBS) waiver program, as authorized in Section 1915(c) of the Social Security Act, carved–out of CalOptima Contract with the DHCS, there was limited participation of Members under the age of 21 with CalOptima's palliative care program. In Orange County, the Health Care Agency (HCA), California Children's Services (CCS) Division was the administrator of the PPC waiver program.

Pursuant to updated federal and state guidance, effective January 1, 2019, MCPs, including CalOptima, became responsible for providing PPC services to eligible CalOptima Medi-Cal members under the age of 21 under their contract relative to the provision of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services specified in Section 1905(r) of the Social Security Act. DHCS guidance, as set forth in APL 18-020: Palliative Care, outlined eligibility criteria for this population, which are more inclusive than those previously developed for the adult population. Eligible conditions for the pediatric population include those that require intensive long-term treatment, are progressive in nature and those that cause severe disability or extreme vulnerability to health complications.

CalOptima and our Health Networks partnered with HCA CCS to coordinate a smooth transition of services for Members participating in the waiver to palliative care services provided by CalOptima as a Medi-Cal benefit.

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Discussion

Palliative care is an approach to care delivery that emphasizes the needs of an individual to have relief of physical, mental and emotional symptoms that are distressing to the individual and their family and that decrease the member's quality of life. Active curative treatment may be sought by the member concurrently with palliative care.

In contrast, hospice care, which is also a Medi-Cal benefit is focused primarily on pain and symptom management and curative treatment is no longer part of the individual's treatment plan. Hospice eligibility requirements specify that the member has a life expectancy of six months or less.

The American Board of Medical Specialties approved the designation of Palliative Care and Hospice as a sub-specialty in 2006 with 10 participating Member Boards. Palliative care services may be delivered in an acute/sub-acute hospital, a nursing facility, in the community, or in-home settings.

The American Academy of Pediatrics published Policy Statement "Pediatric Palliative Care and Hospice Care: Commitments, Guidelines, and Recommendations" (2013). The policy advocates for increased availability and use of palliative care services in the pediatric and adolescent population, not reserving services for those in the last stages of life, but rather including services for those with life-threatening or life-shortening conditions.

Policy GG.1550: Palliative Care Services defines the scope of the palliative care program for CalOptima Medi-Cal members. CalOptima revised this policy to ensure compliance with DHCS APL 18-020: Palliative Care. The revisions include, among other things, clarifying that members under the age of twenty-one (21) years old who do not qualify for palliative care services based on the current minimum eligibility criteria may become eligible for such services according to the broader pediatric palliative care eligibility criteria, and requiring CalOptima or a health network to provide medically necessary palliative care services to members under the age of twenty-one (21) years old who satisfy the pediatric palliative care eligibility criteria consistent with the provision of EPSDT services. The revisions also clarify the minimum necessary seven services for palliative care, including palliative care assessment and consultation and care coordination.

Fiscal Impact

The recommended action to approve revisions to CalOptima Policy GG.1550: Palliative Care Services are operational in nature and do not have an anticipated financial impact beyond what was incorporated in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will ensure that CalOptima policies and procedures meet state requirements related to the delivery of palliative care services.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Policy GG.1550 Palliative Care Services [Medi-Cal] (redline and clean)
2. Board Action Dated December 7, 2017, Consider Approving Palliative Care Policy and Procedure
3. Department of Health Care Services All Plan Letter 18-020

/s/ Michael Schrader *11/26/2019*

Authorized Signature **Date**

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Policy ~~#~~: GG.1550
Title: **Palliative Care Services**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/2018
~~Last Review Date:~~ ~~Not Applicable~~
~~Last~~ Revised Date: ~~Not Applicable~~TBD

FOR 2019 12 05 BOD REVIEW

I. PURPOSE

This policy defines the scope of the Palliative Care program for CalOptima Medi-Cal Members.

II. POLICY

A. Effective January 1, 2018, CalOptima shall provide Palliative Care services to Members as outlined in this Policy, Senate Bill (SB) 1004 (2014) and Department of Health Care Services (DHCS) ~~All Plan Letter 17-015: Palliative Care and Medi-Cal Managed Care~~guidance.

B. CalOptima and its Health Networks shall ~~have a network to ensure~~contract with sufficient providers that ~~Members have effective~~have licensed clinical staff with experience and/or training in Palliative Care in order to provide appropriate access to Palliative Care services.

1. CalOptima or a Health Network may authorize Palliative Care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings. CalOptima or a Health Network must utilize qualified providers for Palliative Care based on the setting and needs of a Member, so long as CalOptima or a Health Network ensures that its providers comply with existing Medi-Cal contracts and policy.

~~1.~~2. CalOptima or a Health Network shall coordinate Palliative Care services utilizing qualified providers, including but not limited to hospitals, long-term care facilities, community clinics, hospice agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in Palliative Care, and based on the setting and needs of the Member.

C. CalOptima or a Health Network shall provide Medically Necessary Palliative Care services to Members ~~meeting all~~who satisfy the ~~following~~ minimum eligibility requirements~~, including at least one (1) of the disease-specific eligibility criteria as~~ described in Section ~~II.E~~III.A. of this Policy~~:~~.

~~a. The Member is likely to or has started to use the hospital or emergency department to manage his or her advanced disease (unanticipated decompensation and not including elective procedures); and~~

~~b.~~a. ~~The Member has an advanced illness as outlined in Section II.E. of this Policy with appropriate documentation of continued decline in health status, and is not eligible~~

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for or declines hospice enrollment; and

c.a. The Member's death within a year would not be unexpected based on clinical status; and

d.a. The Member has either received appropriate patient desired medical therapy, or is a Member for whom Member-desired medical therapy is no longer effective. The Member is not in reversible decompensation; and

e.a. The Member, and if applicable, the Member's family/Member-designated support person agrees to:

i. Attempt, as medically/clinically appropriate, in home, residential based or outpatient disease management/palliative care prior to use of the emergency department, and

ii.i. Participate in Advance Care Planning discussions.

D. Disease-Specific Minimum Eligibility Criteria

a. Congestive Heart Failure (CHF) with both:

iii.i. New York Heart Association (NYHA) heart failure classification III or higher or is hospitalized due to CHF as a primary diagnosis with no further invasive interventions planned; and

iv.i. Has an ejection fraction less than 30 percent (30%) for systolic failure or significant co-morbidities.

b.a. Chronic Obstructive Pulmonary Disease (COPD)

i. Forced Expiratory Volume (FEV) less than 35 percent (35%) of predicted and twenty-four (24) hour oxygen requirement of less than three (3) liters per minute; or

ii.i. Twenty-four (24) hour oxygen requirement of greater than or equal to three (3) liters per minute.

c.a. Advanced cancer with both:

i. Stage III or IV solid organ cancer, lymphoma or leukemia; and

ii.i. A Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy).

d.a. Liver disease with:

a. Irreversible liver damage, serum albumin less than 3.0 and International Normalized Ration, (INR) greater than 1.3, and

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i. Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or

b. Evidence of irreversible liver damage and has a Model for End Stage Liver Disease, (MELD) score of greater than 19.

D. If a Member continues to meet the above minimum eligibility criteria as outlined indescribed in Section III.A. of this Policy or the pediatric Palliative Care eligibility criteria described in Section III.B. of this Policy, he or she may continue to access both Palliative Care and Curative Care until the condition improves, stabilizes, or results in death.

E. Palliative Care services shall include the following services coordinated bywhen Medically Necessary and reasonable for the Provider:palliation or management of a qualified serious illness and related conditions:

1. Advanced Care Planning, including documented discussions between a physician or other qualified healthcare professional and a Member, family member, or legally recognized decision-maker. Counseling that occurs during these discussions shall address, but not be limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST);

2. Palliative Care assessment and consultation, which may be provided at the same time as Advance Care Planning or in subsequent Member conversations. Palliative Care aims to collect both routine medical data and additional personal information not regularly included in a medical history. or Health Risk Assessment. During an initial and/or subsequent Palliative Care consultation or assessment, topics may include, but are not limited to:

   a. Treatment plans, including Palliative Care and Curative Care;

   b. Pain and medication side effects;

   c. Emotional and social challenges;

   d. Spiritual concerns;

   e. Member goals;

   f. Advance Directives, including POLST forms; and

   g. Legally-recognized decision maker.

3. Plan of care developed with the engagement of the Member and/or the Member's Authorized authorized Representativerepresentative. If a Member already has a plan of care, the Provider shall update the plan to reflect any changes resulting from the Palliative Care consultation or Advance Care Planning discussion. The Member's plan of care must include all authorized Palliative Care, including but not limited to pain and symptom management and Curative Care. The plan of care must not include services already received through another Medi-Cal-funded benefit program.

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4. The Palliative Care team shall include a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the Member and the Member's family and are able to assist in identifying sources of pain and discomfort of the Member. This may include, but is not limited to, problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, and/or nausea. The Palliative Care team shall also address other issues such as medication services and allied health needs.

    a. The Palliative Care team may include, but is not limited to, the Member's Primary Care Provider (PCP), a registered nurse, licensed vocational nurse or nurse practitioner, and a social worker. Chaplain services may be part of the Palliative Care team. ~~(Chaplain services are not reimbursable through the Medi-Cal program).~~

    b. The Palliative care team members shall provide all authorized Palliative Care services.

5. Care coordination ~~provided by a member of the Palliative Care team, to ensure~~, ensuring continuous assessment of the Member's needs, and ~~to implement~~implementation of the plan of care~~.~~ shall be provided by a member of the Palliative Care team.

6. Pain and symptom management, utilizing prescription drugs, physical therapy and/or other Medically Necessary services to address a Member's pain and other symptoms. The Member's plan of care shall include all services authorized for pain and symptom management.

7. Mental health and medical social services shall be available to the Member to assist in minimizing the stress and psychological problems that may arise from a serious illness, related conditions, and the dying process. Counseling facilitated by the Palliative Care team may include, but is not limited to:

    a. Psychotherapy;

    b. Bereavement counseling;

    c. Medical social services; and

    d. Discharge planning, as appropriate.

    e. Provision of medical social services shall not duplicate Specialty Mental Health Services provided by the Orange County Health Care Agency (HCA) and shall not change CalOptima's or a Health Network's responsibilities for referring to, and coordinating with the Orange County HCA.

F. CalOptima or a Health Network shall periodically assess for changes in the Member's condition or Palliative Care needs. CalOptima or a Health Network may discontinue Palliative Care that is no longer Medically Necessary or reasonable.

~~G.~~ A Member may receive Palliative Care concurrently with Curative Care and may elect to transition to Hospice Care if the Member meets the hospice eligibility criteria. A Member who is twenty-one (21) years of age or older may not ~~receive~~be concurrently enrolled

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Palliative Care and Hospice Care ~~concurrently, except as described in Section II.J of this policy.~~

~~I.~~G.. A Member under age of twenty-one (21) may be eligible for Palliative Care and Hospice Care services concurrently with Curative Care ~~through other existing programs such as Home and Community Based Services (HCBS) waiver known as Pediatric Palliative Care Program (PPC) or concurrent care under Section 3202 of the Affordable Care Act (ACA).~~.

H. Effective January 1, 2019, CalOptima or a Health Network shall provide Medically Necessary Palliative Care services to Members who satisfy the pediatric Palliative Care eligibility criteria set forth in Section III.B. of this policy consistent with the provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

~~J.~~I. CalOptima or a Health Network shall be responsible for providing Hospice Care services for ~~Terminally Ill~~terminally ill Members in accordance with CalOptima Policy GG.1503: CalOptima Hospice Coverage, Notification and Validation Requirements.

~~K.~~J.For Members enrolled in CalOptima Direct, CalOptima shall be responsible for design, planning and implementation of the Palliative Care program in accordance with this Policy and shall monitor, collect, and analyze referral, encounter and claims data to evaluate the effectiveness of Palliative Care services and to promote continuous quality improvement in accordance with Section III.~~B~~D. of this Policy.

~~L.~~K. Health Networks shall be responsible for design, planning, referrals and implementation of Palliative Care services for their Members, at a minimum, in accordance with SB 1004 (2014) and DHCS ~~APL 17-015: Palliative Care and Medi-Cal Managed Care.~~guidance. CalOptima shall ensure Health Networks comply with SB 1004 (2014) and DHCS ~~APL 17-015: Palliative Care and Medi-Cal Managed Care~~guidance and shall provide oversight of Health Network functions and responsibilities, processes, and performance in accordance with CalOptima Policy GG.1619: Delegation Oversight.

~~M.~~L. A Health Network shall collect and submit to CalOptima Palliative Care enrollment, provider, and utilization data in accordance with CalOptima Policies HH.2003: Health Network and Delegated Entity Reporting, EE.~~1101~~1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory, and EE.1111: Health Network Encounter Reporting Requirements. CalOptima shall provide monitoring and oversight for Health Network enrollment and utilization of Palliative Care services as well as aggregation of data required for DHCS reporting in accordance with GG.1541: Utilization Management Delegation and GG.1532: Over and Under Utilization Monitoring.

III. PROCEDURE

A. Minimum Eligibility Criteria

1. Members of any age are eligible to receive Palliative Care services if they meet all of the criteria outlined in Section III.A.2. below, and at least one of the four requirements outlined in Section III.A.3. below.

2. General Eligibility Criteria

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a. The Member is likely to or has started to use the hospital or emergency department to manage his or her advanced disease (unanticipated decompensation and not including elective procedures); and

b. The Member has an advanced illness as outlined in Section III.E~~I~~A.3. of this Policy with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment; and

c. The Member's death within a year would not be unexpected based on clinical status; and

d. The Member has either received appropriate patient-desired medical therapy or is a Member for whom patient-desired medical therapy is no longer effective. The Member is not in reversible acute decompensation; and

e. The Member, and if applicable, the Member's family/Member-designated support person agrees to:

i. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care prior to use of the emergency department, and

ii. Participate in Advance Care Planning discussions.

3. Disease-Specific Eligibility Criteria

a. Congestive Heart Failure (CHF) with both:

i. New York Heart Association (NYHA) heart failure classification III or higher or is hospitalized due to CHF as a primary diagnosis with no further invasive interventions planned; and

ii. Has an ejection fraction less than 30 percent (30%) for systolic failure or significant co-morbidities.

b. Chronic Obstructive Pulmonary Disease (COPD)

i. Forced Expiratory Volume (FEV) less than 35 percent (35%) of predicted and twenty-four (24)-hour oxygen requirement of less than three (3) liters per minute; or

ii. Twenty-four (24)-hour oxygen requirement of greater than or equal to three (3) liters per minute.

c. Advanced cancer with both:

i. Stage III or IV solid organ cancer, lymphoma or leukemia; and

ii. A Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy).

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d. Liver disease with:

i. Evidence of irreversible liver damage, serum albumin less than 3.0 and International Normalized Ratio (INR) greater than 1.3, and

ii. Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or

iii. Evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

B. Pediatric Palliative Care Eligibility Criteria

1. Members under the age of 21 who do not satisfy the minimum eligibility criteria of Section III.A. of this Policy may become eligible for Palliative Care services if they meet the broader criteria outlined below:

a. The family and/or legal guardian agree to the provision of pediatric Palliative Care services; and

b. There is documentation of a life-threatening diagnosis, which includes but is not limited to:

i. Conditions for which curative treatment is possible, but may fail, including advanced or progressive cancer or complex and severe congenital or acquired heart disease;

ii. Conditions requiring intensive long-term treatment aimed at maintaining quality of life, including human immunodeficiency virus (HIV) infection, cystic fibrosis, or muscular dystrophy;

iii. Progressive conditions for which treatment is exclusively palliative after diagnosis, including progressive metabolic disorders or severe forms of osteogenesis imperfecta; or

iv. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications, including extreme prematurity, severe neurological sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection, or difficult-to-control symptoms.

~~B.~~C. CalOptima or a Health Network shall authorize Palliative Care services when a Member meets the minimum eligibility requirements in accordance with ~~Sections II.C. and E~~Section III.A. of this Policy without regard to the Member's age or the pediatric Palliative Care eligibility criteria in accordance with Section III.B. of this Policy.

1. For a CalOptima Direct Member, a Provider shall submit a routine Prior Authorization Request (ARF) for Palliative Care based on Medical Necessity and eligibility criteria and in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

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~~1.~~2. For a Health Network Member, a Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

~~C.~~D. ~~B.~~ CalOptima shall identify potentially eligible Members for Palliative Care services through various sources, including, but not limited to:

1. Prior Authorization referrals;
2. Concurrent review referrals;
3. Case management referrals;
4. Disease management referrals;
5. Provider referrals; and
6. Claims and encounter data.

~~D.~~E. Provider Training and Education

1. CalOptima shall ensure Provider education and training on Palliative Care services available, identification and referral of eligible Members, and how care will be coordinated between Providers in accordance with CalOptima Policy EE.1103~~:~~A: Provider Education and Training. Provider education shall be provided, at a minimum, as follows:
    a. Provider office education and training;
    b. Provider manual updates;
    c. Provider monthly newsletter; and/or
    d. Provider quarterly Lunch and Learn educational updates.
2. Provider education shall also focus on ensuring Members who are eligible for Palliative Care services are referred from both PCPs, as well as appropriate specialists including, but not limited to:
    a. Oncologists;
    b. Hematologists;
    c. Pulmonologists; and
    d. Cardiologists.

F. CalOptima shall ensure a Member receives Palliative Care services within timely access standards in accordance with CalOptima Policy GG.1600: Access and Availability Standards.

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G. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies GG.1510: ~~Appeals~~Appeal Process ~~for Decisions Regarding Care and Services~~, HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance, and HH.1108: State Hearing Process and Procedures.

H. CalOptima shall report Palliative Care data to DHCS in a manner and format required by DHCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services
B. Department of Health Care Services (DHCS) All Plan Letter ~~17-015~~18-020: Palliative Care ~~and Medi-Cal Managed Care~~
C. Department of Health Care Services (DHCS) All Plan Letter 13-014: Hospice Services and Medi-Cal Managed Care
D. Department of Health Care Services (DHCS) Policy Letter 11-004: The Implementation of Section 2302 of the Affordable Care Act, Entitled "Concurrent Care For Children"
E. CalOptima Policy EE.1101~~:~~Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory
F. CalOptima Policy EE.1103~~:~~Δ: Provider Education and Training
G. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
H. CalOptima Policy GG.1503: CalOptima Hospice Coverage, Notification and Validation Requirements
I. CalOptima Policy GG.1510: ~~Appeals~~Appeal Process ~~for Decisions Regarding Care and Services~~
J. CalOptima Policy GG.1532: Over and Under Utilization Monitoring
K. CalOptima Policy GG.1541: Utilization Management Delegation and
L. CalOptima Policy GG.1600: Access and Availability Standards
M. CalOptima Policy GG.1619: Delegation Oversight
N. CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance
O. CalOptima Policy HH.1108: State Hearing Process and Procedures
P. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
Q. Affordable Care Act, §2302
R. Welfare and Institutions Code §14132.75
S. Centers for Medicare & Medicaid Services (CMS) Letter #10-018: Hospice Care for Children in Medicaid and CHIP

VI. REGULATORY AGENCY APPROVAL(S)

A. 02/06/19: Department of Health Care Services
~~A.~~B. 12/18/17: Department of Health Care Services
~~B.~~C. 11/15/17: Department of Health Care Services

VII. BOARD ACTION(S)

~~None to Date~~
A. 12/07/17: Regular Meeting of the CalOptima Board of Directors

FOR 2019 0205 BOD REVIEW

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VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program
Effective	01/01/2018	GG.1550	Palliative Care Services	Medi-Cal
Revised	TBD	GG.1550	Palliative Care Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Advance Care Planning	Documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker.
Advance Directive	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a Member is incapacitated.
~~Authorized Representative~~	~~Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of the 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 Member's Authorized Representative.~~
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.
Curative Care	Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
Health Network	A Physician Hospital Consortium (PHC), physician 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.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.

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Term	Definition
Hospice Care	The provision of palliative and supportive items and services to a Terminally Ill Member as defined in Title 22 CCR section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider or by others under arrangements made by a hospice provider, including: 1. Nursing services; 2. Physical or occupational therapy, or speech-language pathology; 3. Medical social services under the direction of a physician; 4. Home health aide and homemaker services; 5. Medical supplies and appliances; 6. Drugs and biologicals; 7. Physician Services; 8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility; 9. Counseling, including bereavement, dietary and spiritual counseling; 10. Continuous nursing services provided on a twenty-four (24)-hour basis only during periods of Crisis and only as necessary to maintain the Terminally Ill Member at home; 11. Inpatient Respite Care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility; and 12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.
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.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
Primary Care Provider	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
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.

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Term	Definition
Specialty Mental Health Services	Rehabilitation services, which include 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. Specialty Mental Health Services may also include: 1. Psychiatric Inpatient Hospital Services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; 5. Early Periodic Screening, Detection, and Treatment (EPSDT) supplemental Specialty Mental Health Services; and/or 6. Psychiatric nursing facility services.

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Policy: GG.1550
Title: **Palliative Care Services**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/2018
Revised Date: TBD

FOR 20191205BOD REVIEW

I. PURPOSE

This policy defines the scope of the Palliative Care program for CalOptima Medi-Cal Members.

II. POLICY

A. Effective January 1, 2018, CalOptima shall provide Palliative Care services to Members as outlined in this Policy, Senate Bill (SB) 1004 (2014) and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall contract with sufficient providers that have licensed clinical staff with experience and/or training in Palliative Care in order to provide appropriate access to Palliative Care services.

1. CalOptima or a Health Network may authorize Palliative Care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings. CalOptima or a Health Network must utilize qualified providers for Palliative Care based on the setting and needs of a Member, so long as CalOptima or a Health Network ensures that its providers comply with existing Medi-Cal contracts and policy.

2. CalOptima or a Health Network shall coordinate Palliative Care services utilizing qualified providers, including but not limited to hospitals, long-term care facilities, community clinics, hospice agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in Palliative Care, and based on the setting and needs of the Member.

C. CalOptima or a Health Network shall provide Medically Necessary Palliative Care services to Members who satisfy the minimum eligibility requirements described in Section III.A. of this Policy.

D. If a Member continues to meet the minimum eligibility criteria described in Section III.A. of this Policy or the pediatric Palliative Care eligibility criteria described in Section III.B. of this Policy, he or she may continue to access both Palliative Care and Curative Care until the condition improves, stabilizes, or results in death.

E. Palliative Care services shall include the following services when Medically Necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

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1. Advanced Care Planning, including documented discussions between a physician or other qualified healthcare professional and a Member, family member, or legally recognized decision-maker. Counseling that occurs during these discussions shall address, but not be limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST);

2. Palliative Care assessment and consultation, which may be provided at the same time as Advance Care Planning or in subsequent Member conversations. Palliative Care aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent Palliative Care consultation or assessment, topics may include, but are not limited to:

    a. Treatment plans, including Palliative Care and Curative Care;

    b. Pain and medication side effects;

    c. Emotional and social challenges;

    d. Spiritual concerns;

    e. Member goals;

    f. Advance Directives, including POLST forms; and

    g. Legally-recognized decision maker.

3. Plan of care developed with the engagement of the Member and/or the Member's authorized representative. If a Member already has a plan of care, the Provider shall update the plan to reflect any changes resulting from the Palliative Care consultation or Advance Care Planning discussion. The Member's plan of care must include all authorized Palliative Care, including but not limited to pain and symptom management and Curative Care. The plan of care must not include services already received through another Medi-Cal-funded benefit program.

4. The Palliative Care team shall include a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the Member and the Member's family and are able to assist in identifying sources of pain and discomfort of the Member. This may include, but is not limited to, problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, and/or nausea. The Palliative Care team shall also address other issues such as medication services and allied health needs.

    a. The Palliative Care team may include, but is not limited to, the Member's Primary Care Provider (PCP), a registered nurse, licensed vocational nurse or nurse practitioner, and a social worker. Chaplain services may be part of the Palliative Care team.

    b. The Palliative care team members shall provide all authorized Palliative Care services.

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5. Care coordination, ensuring continuous assessment of the Member's needs, and implementation of the plan of care shall be provided by a member of the Palliative Care team.

6. Pain and symptom management, utilizing prescription drugs, physical therapy and/or other Medically Necessary services to address a Member's pain and other symptoms. The Member's plan of care shall include all services authorized for pain and symptom management.

7. Mental health and medical social services shall be available to the Member to assist in minimizing the stress and psychological problems that may arise from a serious illness, related conditions, and the dying process. Counseling facilitated by the Palliative Care team may include, but is not limited to:

    a. Psychotherapy;

    b. Bereavement counseling;

    c. Medical social services; and

    d. Discharge planning, as appropriate.

    e. Provision of medical social services shall not duplicate Specialty Mental Health Services provided by the Orange County Health Care Agency (HCA) and shall not change CalOptima's or a Health Network's responsibilities for referring to, and coordinating with the Orange County HCA.

F. CalOptima or a Health Network shall periodically assess for changes in the Member's condition or Palliative Care needs. CalOptima or a Health Network may discontinue Palliative Care that is no longer Medically Necessary or reasonable.

G. A Member may receive Palliative Care concurrently with Curative Care and may elect to transition to Hospice Care if the Member meets the hospice eligibility criteria. A Member who is twenty-one (21) years of age or older may not be concurrently enrolled Palliative Care and Hospice Care. A Member under age of twenty-one (21) may be eligible for Palliative Care and Hospice Care services concurrently with Curative Care.

H. Effective January 1, 2019, CalOptima or a Health Network shall provide Medically Necessary Palliative Care services to Members who satisfy the pediatric Palliative Care eligibility criteria set forth in Section III.B. of this policy consistent with the provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

I. CalOptima or a Health Network shall be responsible for providing Hospice Care services for terminally ill Members in accordance with CalOptima Policy GG.1503: CalOptima Hospice Coverage, Notification and Validation Requirements.

J. For Members enrolled in CalOptima Direct, CalOptima shall be responsible for design, planning and implementation of the Palliative Care program in accordance with this Policy and shall monitor, collect, and analyze referral, encounter and claims data to evaluate the effectiveness of Palliative Care services and to promote continuous quality improvement in accordance with Section III.D. of this Policy.

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K. Health Networks shall be responsible for design, planning, referrals and implementation of Palliative Care services for their Members, at a minimum, in accordance with SB 1004 (2014) and DHCS guidance. CalOptima shall ensure Health Networks comply with SB 1004 (2014) and DHCS guidance and shall provide oversight of Health Network functions and responsibilities, processes, and performance in accordance with CalOptima Policy GG.1619: Delegation Oversight.

L. A Health Network shall collect and submit to CalOptima Palliative Care enrollment, provider, and utilization data in accordance with CalOptima Policies HH.2003: Health Network and Delegated Entity Reporting, EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory, and EE.1111: Health Network Encounter Reporting Requirements. CalOptima shall provide monitoring and oversight for Health Network enrollment and utilization of Palliative Care services as well as aggregation of data required for DHCS reporting in accordance with GG.1541: Utilization Management Delegation and GG.1532: Over and Under Utilization Monitoring.

III. PROCEDURE

A. Minimum Eligibility Criteria

1. Members of any age are eligible to receive Palliative Care services if they meet all of the criteria outlined in Section III.A.2. below, and at least one of the four requirements outlined in Section III.A.3. below.

2. General Eligibility Criteria

a. The Member is likely to or has started to use the hospital or emergency department to manage his or her advanced disease (unanticipated decompensation and not including elective procedures); and

b. The Member has an advanced illness as outlined in Section III.A.3. of this Policy with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment; and

c. The Member's death within a year would not be unexpected based on clinical status; and

d. The Member has either received appropriate patient-desired medical therapy or is a Member for whom patient-desired medical therapy is no longer effective. The Member is not in reversible acute decompensation; and

e. The Member, and if applicable, the Member's family/Member-designated support person agrees to:

i. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care prior to use of the emergency department, and

ii. Participate in Advance Care Planning discussions.

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3. Disease-Specific Eligibility Criteria

a. Congestive Heart Failure (CHF) with both:

i. New York Heart Association (NYHA) heart failure classification III or higher or is hospitalized due to CHF as a primary diagnosis with no further invasive interventions planned; and

ii. Has an ejection fraction less than 30 percent (30%) for systolic failure or significant co-morbidities.

b. Chronic Obstructive Pulmonary Disease (COPD)

i. Forced Expiratory Volume (FEV) less than 35 percent (35%) of predicted and twenty-four (24)-hour oxygen requirement of less than three (3) liters per minute; or

ii. Twenty-four (24)-hour oxygen requirement of greater than or equal to three (3) liters per minute.

c. Advanced cancer with both:

i. Stage III or IV solid organ cancer, lymphoma or leukemia; and

ii. A Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy).

d. Liver disease with:

i. Evidence of irreversible liver damage, serum albumin less than 3.0 and International Normalized Ratio (INR) greater than 1.3, and

ii. Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or

iii. Evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

B. Pediatric Palliative Care Eligibility Criteria

1. Members under the age of 21 who do not satisfy the minimum eligibility criteria of Section III.A. of this Policy may become eligible for Palliative Care services if they meet the broader criteria outlined below:

a. The family and/or legal guardian agree to the provision of pediatric Palliative Care services; and

b. There is documentation of a life-threatening diagnosis, which includes but is not limited to:

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i. Conditions for which curative treatment is possible, but may fail, including advanced or progressive cancer or complex and severe congenital or acquired heart disease;

ii. Conditions requiring intensive long-term treatment aimed at maintaining quality of life, including human immunodeficiency virus (HIV) infection, cystic fibrosis, or muscular dystrophy;

iii. Progressive conditions for which treatment is exclusively palliative after diagnosis, including progressive metabolic disorders or severe forms of osteogenesis imperfecta; or

iv. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications, including extreme prematurity, severe neurological sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection, or difficult-to-control symptoms.

C. CalOptima or a Health Network shall authorize Palliative Care services when a Member meets the minimum eligibility requirements in accordance with Section III.A. of this Policy without regard to the Member's age or the pediatric Palliative Care eligibility criteria in accordance with Section III.B. of this Policy.

1. For a CalOptima Direct Member, a Provider shall submit a routine Prior Authorization Request (ARF) for Palliative Care based on Medical Necessity and eligibility criteria and in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

D. CalOptima shall identify potentially eligible Members for Palliative Care services through various sources, including, but not limited to:

1. Prior Authorization referrals;

2. Concurrent review referrals;

3. Case management referrals;

4. Disease management referrals;

5. Provider referrals; and

6. Claims and encounter data.

E. Provider Training and Education

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1. CalOptima shall ensure Provider education and training on Palliative Care services available, identification and referral of eligible Members, and how care will be coordinated between Providers in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training. Provider education shall be provided, at a minimum, as follows:

    a. Provider office education and training;

    b. Provider manual updates;

    c. Provider monthly newsletter; and/or

    d. Provider quarterly Lunch and Learn educational updates.

2. Provider education shall also focus on ensuring Members who are eligible for Palliative Care services are referred from both PCPs, as well as appropriate specialists including, but not limited to:

    a. Oncologists;

    b. Hematologists;

    c. Pulmonologists; and

    d. Cardiologists.

F. CalOptima shall ensure a Member receives Palliative Care services within timely access standards in accordance with CalOptima Policy GG.1600: Access and Availability Standards.

G. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies GG.1510: Appeal Process, HH.1102: Member Grievance, and HH.1108: State Hearing Process and Procedures.

H. CalOptima shall report Palliative Care data to DHCS in a manner and format required by DHCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services
B. Department of Health Care Services (DHCS) All Plan Letter 18-020: Palliative Care
C. Department of Health Care Services (DHCS) All Plan Letter 13-014: Hospice Services and Medi-Cal Managed Care
D. Department of Health Care Services (DHCS) Policy Letter 11-004: The Implementation of Section 2302 of the Affordable Care Act, Entitled “Concurrent Care For Children”
E. CalOptima Policy EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory
F. CalOptima Policy EE.1103Δ: Provider Education and Training
G. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements

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H. CalOptima Policy GG.1503: CalOptima Hospice Coverage, Notification and Validation Requirements
I. CalOptima Policy GG.1510: Appeal Process
J. CalOptima Policy GG.1532: Over and Under Utilization Monitoring
K. CalOptima Policy GG.1541: Utilization Management Delegation and
L. CalOptima Policy GG.1600: Access and Availability Standards
M. CalOptima Policy GG.1619: Delegation Oversight
N. CalOptima Policy HH.1102: Member Grievance
O. CalOptima Policy HH.1108: State Hearing Process and Procedures
P. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
Q. Affordable Care Act, §2302
R. Welfare and Institutions Code §14132.75
S. Centers for Medicare & Medicaid Services (CMS) Letter #10-018: Hospice Care for Children in Medicaid and CHIP

VI. REGULATORY AGENCY APPROVAL(S)

A. 02/06/19: Department of Health Care Services
B. 12/18/17: Department of Health Care Services
C. 11/15/17: Department of Health Care Services

VII. BOARD ACTION(S)

A. 12/07/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	01/01/2018	GG.1550	Palliative Care Services	Medi-Cal
Revised	TBD	GG.1550	Palliative Care Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Advance Care Planning	Documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker.
Advance Directive	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a Member is incapacitated.
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.
Curative Care	Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
Health Network	A Physician Hospital Consortium (PHC), physician 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.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.

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Term	Definition
Hospice Care	The provision of palliative and supportive items and services to a Terminally Ill Member as defined in Title 22 CCR section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider or by others under arrangements made by a hospice provider, including: 1. Nursing services; 2. Physical or occupational therapy, or speech-language pathology; 3. Medical social services under the direction of a physician; 4. Home health aide and homemaker services; 5. Medical supplies and appliances; 6. Drugs and biologicals; 7. Physician Services; 8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility; 9. Counseling, including bereavement, dietary and spiritual counseling; 10. Continuous nursing services provided on a twenty-four (24)-hour basis only during periods of Crisis and only as necessary to maintain the Terminally Ill Member at home; 11. Inpatient Respite Care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility; and 12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.
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.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
Primary Care Provider	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
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.

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Term	Definition
Specialty Mental Health Services	Rehabilitation services, which include 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. Specialty Mental Health Services may also include: 1. Psychiatric Inpatient Hospital Services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; 5. Early Periodic Screening, Detection, and Treatment (EPSDT) supplemental Specialty Mental Health Services; and/or 6. Psychiatric nursing facility services.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Approving Palliative Care Policy and Procedure (P&P) and Authorizing Execution of Agreement with the Department of Health Care Services to Fund the P&P's Implementation

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Tracy Hitzeman, RN, Executive Director, Clinical Operations, (714) 246-8400

Recommended Actions

1. Approve CalOptima's palliative care policy and procedure; and
2. Authorize and direct the Chairman of the CalOptima Board of Directors to execute a stand-alone agreement with the Department of Health Care Services (DHCS) to fund implementation of the palliative care policies and procedures.

Background

Senate Bill 1004 (Hernandez, Chapter 574, Statutes of 2014) requires the DHCS to "establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services." As palliative care is already a benefit, DHCS has indicated there will be no rate adjustment for managed Medi-Cal plans. CalOptima intends to compensate providers on a fee-for-service basis for services provided in the direct networks (CalOptima Community Network and CalOptima Direct) using the standard CalOptima contracting processes and fee schedule.

Several technical assistance meetings have been held by DHCS with managed care plans, providers and other stakeholders. In October 2017, APL 17-015 Palliative Care and Medi-Cal Managed Care was published. The APL provides managed care plans with direction to approve palliative care services when a beneficiary meets minimum general and disease-specific eligibility criteria, effective January 1, 2018.

On November 15, 2017, DHCS sent CalOptima a draft contract to allow DHCS to fund the development of CalOptima's Palliative Care policies and procedures as a one-time payment in the amount of $50,000. CalOptima staff developed these documents and forwarded them to DHCS for review. On November 15, 2017 DHCS approved this P&P.

Discussion

Palliative care is an approach to care delivery that emphasizes the needs of an individual to have relief of physical, mental and emotional symptoms that are distressing to the individual and their family and that decrease the member's quality of life. Active curative treatment may be sought by the member concurrently with palliative care.

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The American Board of Medical Specialties approved the designation of Palliative Care and Hospice as a sub-specialty in 2006 with 10 participating Member Boards. Palliative care services may be delivered in an acute/sub-acute hospital, a nursing facility, in the community, or in-home settings.

Many of CalOptima's Health Networks already have well-structured palliative care services program. Additional funding from the state will be used to implement the Palliative Care Policy and Procedures including outreach and education to practitioners, networks and other providers, oversight of delegated entities and data collection, analysis and submission to DHCS. CalOptima's implementation of APL 17-015 Palliative Care and Managed Medi-Cal will increase awareness of the palliative care, provide uniform reporting of the services, meet the requirements as outlined in SB 1004 and most importantly, increase member access to these services.

Numerous studies have demonstrated, and it is CalOptima's and DHCS' assumption, that palliative care can prevent inappropriate utilization of services. Using reporting processes that will be implemented pursuant to the attached policy, CalOptima will be able to better analyze palliative care services and its overall cost. We anticipate that the resulting data will affirm those assumptions.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, included expenses related to palliative care services, as one component of overall medical costs. Due to the challenges associated with quantifying specific costs and savings, the budget did not include forecasts specific to palliative care services. However, staff believes the use of palliative care services for appropriate individuals are expected to result in an overall decrease to the cost of care or be budget neutral.

Rationale for Recommendation

The actions recommended will support ongoing and increased focus on addressing CalOptima members' relief of physical, mental and emotional symptoms, while allowing for continued access to curative care in the instances of significant illness. By addressing needs in a proactive, structured and consistent manner, the member will experience an improved quality of life and decreased incidence of uncontrolled symptoms that may lead to inappropriate ED visits, hospitalizations and other medical services. Additionally, the implementation of the policy and procedure will allow CalOptima to adhere to DHCS reporting requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

CalOptima Policy No. GG.1550, Palliative Care Services

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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Policy #:	GG.1550
Title:	**Palliative Care Services**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2018
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

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I. PURPOSE

This policy defines the scope of the Palliative Care program for CalOptima Medi-Cal Members.

II. POLICY

A. Effective January 1, 2018, CalOptima shall provide Palliative Care services to Members as outlined in this Policy, Senate Bill (SB) 1004 (2014) and Department of Health Care Services (DHCS) All Plan Letter 17-015: Palliative Care and Medi-Cal Managed Care.

B. CalOptima and its Health Networks shall have a network to ensure that Members have effective and appropriate access to Palliative Care services.

C. CalOptima or a Health Network shall coordinate Palliative Care services utilizing qualified providers, including but not limited to hospitals, long-term care facilities, community clinics, hospice agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in Palliative Care, and based on the setting and needs of the Member.

D. CalOptima or a Health Network shall provide Medically Necessary Palliative Care services to Members meeting all the following minimum eligibility requirements, including at least one (1) of the disease-specific eligibility criteria as described in Section II.E. of this Policy:

1. The Member is likely to or has started to use the hospital or emergency department to manage his or her advanced disease (unanticipated decompensation and not including elective procedures); and

2. The Member has an advanced illness as outlined in Section II.E. of this Policy with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment; and

3. The Member's death within a year would not be unexpected based on clinical status; and

4. The Member has either received appropriate patient desired medical therapy, or is a Member for whom Member-desired medical therapy is no longer effective. The Member is not in reversible decompensation; and

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5. The Member, and if applicable, the Member's family/Member-designated support person agrees to:

    a. Attempt, as medically/clinically appropriate, in-home, residential-based or outpatient disease management/palliative care prior to use of the emergency department, and

    b. Participate in Advance Care Planning discussions.

E. Disease-Specific Minimum Eligibility Criteria

1. Congestive Heart Failure (CHF) with both:

    a. New York Heart Association (NYHA) heart failure classification III or higher or is hospitalized due to CHF as a primary diagnosis with no further invasive interventions planned; and

    b. Has an ejection fraction less than 30 percent (30%) for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease (COPD)

    a. Forced Expiratory Volume (FEV) less than 35 percent (35%) of predicted and twenty-four (24)-hour oxygen requirement of less than three (3) liters per minute; or

    b. Twenty-four (24)-hour oxygen requirement of greater than or equal to three (3) liters per minute.

3. Advanced cancer with both:

    a. Stage III or IV solid organ cancer, lymphoma or leukemia; and

    b. A Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver disease with:

    a. Irreversible liver damage, serum albumin less than 3.0 and International Normalized Ration, (INR) greater than 1.3, and

    b. Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or

    c. Evidence of irreversible liver damage and has a Model for End Stage Liver Disease, (MELD) score of greater than 19.

F. If a Member continues to meet the above minimum eligibility criteria as outlined in this Policy, he or she may continue to access both Palliative Care and Curative Care until the condition improves, stabilizes, or results in death.

G. Palliative Care services shall include the following services coordinated by the Provider:

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1. Advanced Care Planning, including documented discussions between a physician or other qualified healthcare professional and a Member, family member, or legally recognized decision-maker. Counseling that occurs during these discussions shall address, but not be limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST);

2. Palliative Care assessment and consultation, which may be provided at the same time as Advance Care Planning or in subsequent Member conversations to collect both routine medical data and additional personal information not regularly included in a medical history. During an initial and/or subsequent Palliative Care consultation or assessment, topics may include, but are not limited to:

    a. Treatment plans, including Palliative Care and Curative Care;

    b. Pain and medication side effects;

    c. Emotional and social challenges;

    d. Spiritual concerns;

    e. Member goals;

    f. Advance Directives, including POLST forms; and

    g. Legally-recognized decision maker.

3. Plan of care developed with the engagement of the Member and/or the Member's Authorized Representative. If a Member already has a plan of care, the Provider shall update the plan to reflect any changes resulting from the Palliative Care consultation or Advance Care Planning discussion. The Member's plan of care must include all authorized Palliative Care, including but not limited to pain and symptom management and Curative Care. The plan of care must not include services already received through another Medi-Cal-funded benefit program.

4. The Palliative Care team shall include a group of individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of the Member and the Member's family and are able to assist in identifying sources of pain and discomfort of the Member. This may include, but is not limited to, problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, and/or nausea. The Palliative Care team shall also address other issues such as medication services and allied health needs.

    a. The Palliative Care team may include, but is not limited to, the Member's Primary Care Provider (PCP), a registered nurse, licensed vocational nurse or nurse practitioner, and a social worker. Chaplain services may be part of the Palliative Care team.

    b. The Palliative care team members shall provide all authorized Palliative Care services.

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5. Care coordination provided by a member of the Palliative Care team, to ensure continuous assessment of the Member's needs and to implement the plan of care.

6. Pain and symptom management, utilizing prescription drugs, physical therapy and/or other Medically Necessary services to address a Member's pain and other symptoms. The Member's plan of care shall include all services authorized for pain and symptom management.

7. Mental health and medical social services shall be available to the Member to assist in minimizing the stress and psychological problems that may arise from a serious illness, related conditions, and the dying process. Counseling facilitated by the Palliative Care team may include, but is not limited to:

   a. Psychotherapy;

   b. Bereavement counseling;

   c. Medical social services; and

   d. Discharge planning, as appropriate.

   e. Provision of medical social services shall not duplicate Specialty Mental Health Services provided by the Orange County Health Care Agency (HCA) and shall not change CalOptima's or a Health Network's responsibilities for referring to, and coordinating with the Orange County HCA.

H. CalOptima or a Health Network shall periodically assess for changes in the Member's condition or Palliative Care needs. CalOptima or a Health Network may discontinue Palliative Care that is no longer Medically Necessary or reasonable.

I. A Member may receive Palliative Care concurrently with Curative Care and may elect to transition to Hospice Care if the Member meets the hospice eligibility criteria. A Member may not receive Palliative Care and Hospice Care concurrently, except as described in Section II.J of this policy.

J. A Member under age of twenty-one (21) may be eligible for Palliative Care and Hospice Care services concurrently with Curative Care through other existing programs such as Home and Community Based Services (HCBS) waiver known as Pediatric Palliative Care Program (PPC) or concurrent care under Section 3202 of the Affordable Care Act (ACA).

K. CalOptima or a Health Network shall be responsible for providing Hospice Care services for Terminally Ill Members in accordance with CalOptima Policy GG.1503: CalOptima Hospice Coverage, Notification and Validation Requirements.

L. For Members enrolled in CalOptima Direct, CalOptima shall be responsible for design, planning and implementation of the Palliative Care program in accordance with this Policy and shall monitor, collect, and analyze referral, encounter and claims data to evaluate the effectiveness of Palliative Care services and to promote continuous quality improvement in accordance with Section III.B. of this Policy.

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M. Health Networks shall be responsible for design, planning, referrals and implementation of Palliative Care services for their Members, at a minimum, in accordance with SB 1004 (2014) and DHCS APL 17-015: Palliative Care and Medi-Cal Managed Care. CalOptima shall ensure Health Networks comply with SB 1004 (2014) and DHCS APL 17-015: Palliative Care and Medi-Cal Managed Care and shall provide oversight of Health Network functions and responsibilities, processes, and performance in accordance with CalOptima Policy GG.1619: Delegation Oversight.

N. A Health Network shall collect and submit to CalOptima Palliative Care enrollment, provider, and utilization data in accordance with CalOptima Policies HH.2003: Health Network Reporting, EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory, and EE.1111: Health Network Encounter Reporting Requirements. CalOptima shall provide monitoring and oversight for Health Network enrollment and utilization of Palliative Care services as well as aggregation of data required for DHCS reporting in accordance with GG.1541: Utilization Management Delegation and GG.1532: Over and Under Utilization Monitoring.

III. PROCEDURE

A. CalOptima or a Health Network shall authorize Palliative Care services when a Member meets the minimum eligibility requirements in accordance with Sections II.C. and E. of this Policy without regard to the Member's age.

1. For a CalOptima Direct Member, a Provider shall submit a routine Prior Authorization Request (ARF) for Palliative Care based on Medical Necessity and eligibility criteria and in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals. For a Health Network Member, a Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

B. CalOptima shall identify potentially eligible Members for Palliative Care services through various sources, including, but not limited to:

1. Prior Authorization referrals;

2. Concurrent review referrals;

3. Case management referrals;

4. Disease management referrals;

5. Provider referrals; and

6. Claims and encounter data.

C. Provider Training and Education

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1. CalOptima shall ensure Provider education and training on Palliative Care services available, identification and referral of eligible Members, and how care will be coordinated between Providers in accordance with CalOptima Policy EE.1103: Provider Education and Training. Provider education shall be provided, at a minimum, as follows:

    a. Provider office education and training;

    b. Provider manual updates;

    c. Provider monthly newsletter; and/or

    d. Provider quarterly Lunch and Learn educational updates.

2. Provider education shall also focus on ensuring Members who are eligible for Palliative Care services are referred from both PCPs, as well as appropriate specialists including, but not limited to:

    a. Oncologists;

    b. Hematologists;

    c. Pulmonologists; and

    d. Cardiologists.

D. CalOptima shall ensure a Member receives Palliative Care services within timely access standards in accordance with CalOptima Policy GG.1600: Access and Availability.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services, HH.1102: CalOptima Member Complaint, and HH.1108: State Hearing Process and Procedures.

F. CalOptima shall report Palliative Care data to DHCS in a manner and format required by DHCS.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services
B. Department of Health Care Services (DHCS) All Plan Letter 17-015: Palliative Care and Medi-Cal Managed Care
C. Department of Health Care Services (DHCS) All Plan Letter 13-014: Hospice Services and Medi-Cal Managed Care
D. Department of Health Care Services (DHCS) Policy Letter 11-004: The Implementation of Section 2302 of the Affordable Care Act, Entitled “Concurrent Care For Children”

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E. CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory
F. CalOptima Policy EE.1103: Provider Education and Training
G. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
H. CalOptima Policy GG.1503: CalOptima Hospice Coverage, Notification and Validation Requirements
I. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
J. CalOptima Policy GG.1532: Over and Under Utilization Monitoring
K. CalOptima Policy GG.1541: Utilization Management Delegation and
L. CalOptima Policy GG.1600: Access and Availability
M. CalOptima Policy GG.1619: Delegation Oversight
N. CalOptima Policy HH.1102: CalOptima Member Complaint
O. CalOptima Policy HH.1108: State Hearing Process and Procedures
P. CalOptima Policy HH.2003: Health Network Reporting
Q. Affordable Care Act, §2302
R. Welfare and Institutions Code §14132.75

VI. REGULATORY AGENCY APPROVALS

A. 11/15/17: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2018	GG.1550	Palliative Care Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Advance Care Planning	Documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker.
Advance Directive	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a Member is incapacitated.
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of the 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 Member's Authorized Representative.
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.
Curative Care	Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress
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.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.

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Term	Definition
Hospice Care	The provision of palliative and supportive items and services to a Terminally Ill Member as defined in Title 22 CCR section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider or by others under arrangements made by a hospice provider, including: 1. Nursing services; 2. Physical or occupational therapy, or speech-language pathology; 3. Medical social services under the direction of a physician; 4. Home health aide and homemaker services; 5. Medical supplies and appliances; 6. Drugs and biologicals; 7. Physician Services; 8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility; 9. Counseling, including bereavement, dietary and spiritual counseling; 10. Continuous nursing services provided on a twenty-four (24)-hour basis only during periods of Crisis and only as necessary to maintain the Terminally Ill Member at home; 11. Inpatient Respite Care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility; and 12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.
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.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
Primary Care Provider	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
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.

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Term	Definition
Specialty Mental Health Services	Rehabilitation services, which include 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. Specialty Mental Health Services may also include: 1. Psychiatric Inpatient Hospital Services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; 5. Early Periodic Screening, Detection, and Treatment (EPSDT) supplemental Specialty Mental Health Services; and/or 6. Psychiatric nursing facility services.

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 7, 2018

ALL PLAN LETTER 18-020
SUPERSEDES ALL PLAN LETTER 17-015

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PALLIATIVE CARE

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their obligation to provide palliative care to their members pursuant to Senate Bill (SB) 1004 (Hernandez, Chapter 574, Statutes of 2014) and under their contract relative to the provision of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services.[1] The requirements discussed in this APL specifically apply to Medi-Cal managed care members who are not dually eligible for Medicare and Medi-Cal.

BACKGROUND:
SB 1004 requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to MCPs for the delivery of palliative care.[2] Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the MCP contracts and does not affect a member's eligibility to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care.

Hospice care is a Medi-Cal benefit that serves terminally ill members. It consists of interventions that focus primarily on pain and symptom management rather than a cure or the prolongation of life. To qualify for hospice care, a Medi-Cal member must have a life expectancy of six months or less. Further information regarding Medi-Cal hospice care is available in APL 13-014, titled "Hospice Services and Medi-Cal Managed Care," including any future iterations of this APL.[3]

[1] SB 1004 (Chapter 574, Statues of 2014) is available at:
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB1004
[2] Welfare and Institutions Code (WIC) Section 14132.75. WIC Section 14132.75 is available at:
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.75.&lawCode=WIC
[3] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if the member meets the hospice eligibility criteria. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care.

A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302, as detailed in CMS Letter #10-018.[4] Information regarding the concurrent care policy is available in Policy Letter (PL) 11-004, titled "The Implementation of Section 2302 of the Affordable Care Act, titled 'Concurrent Care for Children'"; APL 13-014; and the appropriate California Children's Services (CCS) Numbered Letter (NL), including any future iterations of these letters.[5, 6] Additionally, members who are eligible for EPSDT may receive other services.[7] Accordingly, MCPs must provide EPSDT eligible members with any other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services, whether or not such services are covered under the California State Plan. Services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, to prolong life, and promote physical, and mental health and efficiency.[8] Information regarding the policy for EPSDT services is available in APL 18-007, titled "Requirements of Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Who Transition into Medi-Cal Managed Care," including any future iterations of this APL.

POLICY:
DHCS' SB 1004 Medi-Cal Palliative Care Policy specifies the minimum types of palliative care services that MCPs must authorize when medically necessary for members who meet the eligibility criteria.[9] MCPs must either adopt DHCS' minimum

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[4] CMS Letter #10-018 is available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10018.pdf
[5] PLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx
[6] CCS Numbered Letters is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] Social Security Act (SSA) Section 1905(r). SSA Section 1905 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
[8] 42 Code of Regulations (CFR) Section 440.130(c). 42 CFR Section 440 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=5f07d61ecd1e2d138f81e7c2e597e172&mc=true&node=pt42.4.440&rgn=div5
[9] DHCS' SB 1004 Medi-Cal Palliative Care Policy, dated November 2017, is available at: http://www.dhcs.ca.gov/provgovpart/Documents/SB1004PalliativeCarePolicyDoc11282017.pdf

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eligibility criteria for palliative care, or they may submit broader eligibility criteria to DHCS for approval.

I. Eligibility Criteria

Members of any age are eligible to receive palliative care services if they meet all of the criteria outlined in Section I.A. below, and at least one of the four requirements outlined in Section I.B.

Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in Section I.C. below, consistent with the provision of EPSDT services.

A. General Eligibility Criteria:

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.

2. The member has an advanced illness, as defined in section I.B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.

3. The member's death within a year would not be unexpected based on clinical status.

4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.

5. The member and, if applicable, the family/member-designated support person, agrees to:
    a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    b. Participate in Advance Care Planning discussions.

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B. Disease-Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
    a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher;[10] and
    b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)
    a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
    b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
    a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone
    a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.[11]

[10] NYHA classifications are available at: http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.WefN7rpFxxo
[11] The MELD score calculator is available at: https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator

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C. Pediatric Palliative Care Eligibility Criteria:

Must meet (a) and (b) listed below. Members under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.[12]

a. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
b. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
    1. Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
    2. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
    3. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
    4. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. MCPs must have a process to identify members who are eligible for palliative care, including a provider referral process.[13] MCPs must periodically assess the member for changes in the member's condition or palliative care needs. MCPs may discontinue palliative care that is no longer medically necessary or no longer reasonable.

For children who have an approved CCS-eligible condition, CCS remains responsible (in non-Whole Child Model counties) for medical treatment for the CCS-eligible condition, and the MCP is responsible for the provision of palliative care services related to the CCS-eligible condition.

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[12] CMS Letter #10-018 is available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10018.pdf

[13] MCPs may receive referrals from in-network or out-of-network providers, such as primary care providers, specialty providers, and Specialty Care Centers. MCPs must review all referrals received to make medical necessity determinations for palliative care services.

II. Palliative Care Services

Effective January 1, 2018, when a member meets the minimum eligibility criteria for palliative care, MCPs must authorize palliative care without regard to age. Palliative care must include, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

A. Advance Care Planning: Advance care planning for members enrolled in Medi-Cal palliative care under SB 1004 includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms. Please refer to the section on advance care planning in the Provider Manual for further details.[14]

B. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:
    - Treatment plans, including palliative care and curative care
    - Pain and medicine side effects
    - Emotional and social challenges
    - Spiritual concerns
    - Patient goals
    - Advance directives, including POLST forms
    - Legally-recognized decision maker

C. Plan of Care: A plan of care should be developed with the engagement of the member and/or the member's representative(s) in its design. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care. The plan of care

[14] Medi-Cal Provider Manual Evaluation and Management is available at http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eval_m00o03.doc.

must not include services already received through another Medi-Cal funded benefit program (e.g. CCS Program).

D. Palliative Care Team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of a member and of the member's family and are able to assist in identifying the member's sources of pain and discomfort. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members must provide all authorized palliative care. DHCS recommends that the palliative care team include, but is not limited to the following team members: a doctor of medicine or osteopathy (Primary Care Provider if MD or DO); a registered nurse; a licensed vocational nurse or nurse practitioner (NP) (Primary Care Provider if NP); and a social worker. DHCS also recommends that MCPs provide access to chaplain services as part of the palliative care team. Chaplain services provided as palliative care are not reimbursable through the Medi-Cal program.

E. Care Coordination: A member of the palliative care team must provide coordination of care, ensure continuous assessment of the member's needs, and implement the plan of care.

F. Pain and Symptom Management: The member's plan of care must include all services authorized for pain and symptom management. Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address a member's pain and other symptoms.

Mental Health and Medical Social Services: Counseling and social services must be available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. Provision of medical social services must not duplicate specialty mental health services provided by county Mental Health Plans (MHPs). Furthermore, provision of medical and social services does not change the MCP's responsibility for referring to, and coordinating with, county MHPs, as delineated in APL 17-018 "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services," including any subsequent revisions.

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MCPs must have a process to determine the type of palliative care that is medically necessary or reasonable for eligible members. MCPs must have an adequate network of palliative care providers to meet the needs of their members.

Furthermore, MCPs may authorize additional palliative care not described above, at the MCP's discretion and cost. Examples of additional services offered by many community-based palliative care programs include a telephonic palliative care support line that is separate from a routine advice line and is available 24 hours a day/7 days a week, and expressive therapies, such as creative art, music, massage and play therapy, for the pediatric population.

III. Providers

MCPs may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings. MCPs must utilize qualified providers for palliative care based on the setting and needs of a member, so long as the MCP ensures that its providers comply with existing Medi-Cal contracts and policy. DHCS recommends that MCPs use providers who possess current palliative care training and/or certification to conduct palliative care consultations or assessments.

MCPs may contract with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in palliative care. MCPs may contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services facilities may be considered palliative care partners for facilitating advance care planning or palliative care referrals. Palliative care provided in a member's home must comply with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans. MCPs must inform and educate providers regarding availability of the palliative care benefit.

IV. MCP Policies and Procedures

The MCP's written policies and procedures for palliative care must describe the MCP's policy to meet the requirements for the palliative care benefit as indicated within this APL, including how MCPs will monitor and collect palliative care enrollment, provider, and utilization data to report to DHCS, as specified.

MCPs are responsible for ensuring that their delegates and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other

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DHCS guidance, including APLs and PLs. MCPs must communicate these requirements to all their delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment

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Attachment A: Palliative Care Resources

DHCS SB 1004 Palliative Care Website: Materials available related to SB 1004. Please send questions to: SB1004@dhcs.ca.gov

California HealthCare Foundation (CHCF): Wide range of online materials and resources, as well as in-person technical assistance events.

Coalition for Compassionate Care of California: Consumer and provider resources on advance care planning and palliative care. Also frequent webinars and training programs.

California State University Institute for Palliative Care: Instructor-led and self-paced online training in palliative care, advance care planning, and case management for health care professionals, including health plan case managers, as well as for patients and families.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
10. Consider Approval of Modifications to CalOptima's Medical Policies and Procedures

Contact
David Ramirez, M.D., Chief Medical Officer (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations (714) 246-8400

Recommended Action(s)
Authorize updates to the existing Policies and Procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows:

1. GG.1105: Coverage for Organ Tissue Transplant [Medi-Cal]
2. MA.6044: Coverage of Solid Organ and Stem Cell Transplants [OneCare, OneCare Connect]
3. GG.1327: Coordination for Dual-Eligible members, Not Enrolled in OneCare Connect, with LTSS [Medi-Cal]
4. GG.1423: Medication Quality Assurance Program [Medi-Cal]

Background/Discussion

CalOptima updates its Policies and Procedures to comply with new regulatory programs. Most recently CalOptima implemented the Whole Child Model on July 1, 2019 and will implement the Health Homes Program on January 1, 2020.

Whole Child Model (WCM): The California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children under age 21 who meet eligibility criteria based on financial and medical conditions. Beginning July 1, 2019 CCS services were incorporated into CalOptima.

Health Homes Program (HHP): The HHP is designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports needed by eligible members. Implementation is expected to begin January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and Substance Use Disorders (SUD), and July 1, 2020, for CalOptima Medi-Cal members with eligible Serious Mental Illness (SMI).

Below is information regarding additional policies that require modification including revisions related to WCM and HHP, as well as some clarification related to existing operations:

1. ***GG.1105: Coverage for Organ Tissue Transplant*** outlines the transplant coverage for CalOptima members under the Medi-Cal program. CalOptima revised this policy pursuant to the CalOptima annual review process to ensure policy compliance with the implementation of the WCM program and the DHCS APL 18-023: California Children's Services WCM. Revisions include extending the coverage to CCS-eligible members and providing clarity regarding

approved CCS-approved Special Care Centers where CCS-eligible members may receive services.

2. ***MA.6044: Coverage of Solid Organ and Stem Cell Transplants*** outlines the coverage of solid organ and stem cell transplants and related care and services for CalOptima members in the OneCare and OneCare Connect programs. CalOptima developed this new policy to specifically address OneCare and OneCare Connect members. This policy language was previously contained in CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants.

3. ***GG.1327: Coordination for Dual-Eligible Members, Not Enrolled in OneCare Connect, with LTSS*** was revised pursuant to the CalOptima annual review process to ensure compliance with Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements, clarify appropriate referral of HHP, remove references to SPD members, and align the policy with current operational processes and regulatory requirements.

4. ***GG.1423: Medication Quality Assurance Program*** was revised pursuant to the CalOptima review process to ensure alignment with current operational processes and regulatory requirements to include compliance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements. The policy clarifies the requirements for Medication management tools, including e-prescribing, drug formulary checks, and medication reconciliation.

Fiscal Impact

The recommended actions to revise CalOptima Policies GG.1105, MA.6044, GG.1327 and GG.1423 are operational in nature. Staff does not anticipate any additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2019-20 Operating Budget, approved by the Board on June 6, 2019.

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

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Attachments

1. GG.1105: Coverage for Organ Tissue Transplant [Medi-Cal] (redline and clean)
2. MA.6044: Coverage of Solid Organ and Stem Cell Transplants [OneCare, OneCare Connect] (redline and clean)
3. GG.1327: Coordination for Dual-Eligible Members, Not Enrolled in OneCare Connect, with LTSS [Medi-Cal]
4. GG.1423: Medication Quality Assurance Program [Medi-Cal]
5. Board Action April 4, 2019, Consider Actions Related to CalOptima's Whole-Child Model (WCM) Program
6. Board Action May 2, 2019, Consider Approval of Modifications to CalOptima's Policy and Procedure Related to CalOptima's Whole-Child Model Program
7. Board Action October 3, 2019, Consider Modifications to CalOptima Policies and Procedures related to various regulatory and business requirements
8. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program
9. DHCS Whole Child Model Network Certification Requirements for Delegated Entities
10. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
11. Department of Health Care Services. Medi-Cal Health Homes Program, Program Guide 7/1/19
12. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

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Policy #:	GG.1105
Title:	**Coverage of Organ and Tissue Transplants**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/1995
~~Last Review Date:~~	~~08/01/17~~
~~Last~~ Revised Date:	TBD~~08/01/17~~
~~Applicable to:~~	☒ ~~Medi-Cal~~ ☒☐ ~~OneCare~~ ☒☐ ~~OneCare Connect~~

FOR 20191205 BOD REVIEW

I. PURPOSE

This policy defines Transplant coverage for CalOptima Members ~~under the Medi-Cal program~~.

II. POLICY

A. A Transplant shall be a Covered Service if a Member meets the patient selection criteria as defined in Section II.B. of this policy:

1. ~~For the Medi-Cal and OneCare Connect program, a~~A Transplant shall be a Covered Service~~,~~ if a Member is twenty-one (21) years of age or older.

2. ~~For the Medi-Cal program~~Effective July 1, 2019, a Transplant shall be a ~~service covered under the California Children's Services (CCS) program~~Covered Service for Members eligible ~~Members less than twenty-one (21) years of age.~~with the Whole-Child Model (WCM) program.

B. Selection Criteria

1. A Transplant shall be a Covered Service upon CalOptima's or a Health Network's determination that the Member is a candidate for a Transplant, is compliant with all requirements, and does not have significant contraindications for the Transplant~~.~~ as follows:

   a. ~~CalOptima~~ Except for Members enrolled in a Health Maintenance Organization (HMO) that is responsible for all Covered Services for its assigned Members under its contract with CalOptima, CalOptima shall be responsible for the provision and payment of ~~all services~~ Covered Services related to the Transplant, including~~,~~ but not limited to~~,~~ evaluation of potential Donors and procurement from living~~,~~ or deceased~~,~~ Donors~~.~~ in accordance with this Policy and CalOptima Policies GG.1313: Coordination of Care for Transplant Members, FF.1005a Special Payments – Bone Marrow Transplant and Solid Organ Transplant and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. A Transplant~~,~~ and related services~~,~~ shall be Covered Services if:

   a. A Provider or Practitioner obtains authorization for these services from CalOptima in accordance with CalOptima Policies GG.1500 Authorization Instructions for CalOptima

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Direct and CalOptima Community Network Providers, GG.1508 Authorization and Processing of Referrals and GG.1535 Utilization Review Criteria and Guidelines;

~~a.~~b. The Transplant is performed in ~~a Centers for Medicare & Medicaid Services (CMS) or Department of Health Care Services (DHCS)~~ an approved ~~Transplant Center for that specific Transplant~~facility, as set forth in Section III.A. of this policy; and

~~b.~~c. The Member ~~meets~~is accepted at the ~~patient selection criteria~~approved facility for the following Transplants:

i. Heart;

ii. Heart and lung;

iii. Lung;

iv. Bone marrow;

v. Liver;

vi. Small bowel;

vii. Kidney;

viii. Pancreas;

ix. Combined liver and kidney;

x. Combined liver and small bowel;

xi. Combined kidney and pancreas; and/or

xii. Cornea, skin, tendon and sclera transplants.

4. Renal Transplants

a. A renal Transplant and related services are Covered Services if the Transplant is performed at a ~~CMS or~~ DHCS-approved Transplant Center.

b. ~~For Medi-Cal Members,~~ A renal Transplant and related services are Covered Services for Members with a CCS-eligible condition if the Transplant is performed at a DHCS-approved Special Care Renal Dialysis and Transplant Center.

~~b.~~c. CalOptima shall consider the selection criteria for a renal Transplant as met if CalOptima determines that the Transplant is Medically Necessary, in accordance with Title 22, California Code of Regulations (CCR.), Sections 51003 and 51218.

~~c.~~d. CalOptima is responsible for the provision of all services related to a renal Transplant including, but not limited to, evaluation of potential Donors and nephrectomy from living, or deceased, Donors.

5. Cornea, Skin, Tendon, and Sclera Transplants

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a. A Transplant and related services for cornea, skin, tendon, and sclera are Covered Services if the Transplant is performed at a ~~Medicare or~~ Medi-Cal facility or at a designated Special Care Center for Members with a CCS-eligible condition.

b. CalOptima shall consider the selection criteria for such Transplants as met if CalOptima determines that the Transplant is Medically Necessary, in accordance with Title 22, California Code of Regulations (CCR), Section 51003.

III. PROCEDURE

A. ~~CMS- and~~ DHCS-approved Transplant Centers and CCS-approved Transplant Special Care Centers

1. A ~~CMS- or~~ DHCS-approved Transplant Center ~~for all Transplants, excluding renal transplants,~~ is a facility that is approved by ~~CMS or~~ DHCS to provide specific Transplant services for Medi-Cal Members.

2. A ~~CMS- or~~CCS-approved Transplant Center for all Transplants is a Special Care Center that is approved by DHCS, to provide specific Transplant Services for CCS WCM-eligible Members~~.~~ as determined by CCS in accordance with CalOptima Policy GG.1101:— Whole-Child Model / California Children's Services.

~~2.~~3. A DHCS-approved Transplant Center for a renal Transplant for a renal Transplant is a facility that:

a. Is certified for, and participates in, the Medicare program;

b. Meets standards established by CMS~~,~~ or DHCS; and

c. Is certified by DHCS, to participate in the Medi-Cal program.

~~3.~~4. CalOptima or a Health Network shall identify a ~~CMS- or~~ DHCS CCS-approved Transplant Special Care Center~~,~~ based upon information, documentation~~,~~ and representation received from ~~CMS~~DHCS and ~~DHCS~~CCS.

~~4.~~5. CalOptima's Chief Medical Officer (CMO)~~,~~ or Designee~~,~~ shall have the authority to determine CalOptima coverage of a Transplant performed at a ~~CMS- or~~ DHCS-approved Transplant Center, whose certification by ~~CMS or~~ DHCS is probationary.

6. CalOptima's Chief Medical Officer (CMO)~~,~~ or Designee~~,~~ shall have the authority to determine CalOptima coverage of a Transplant performed at a DHCS- and CCS-approved Transplant Special Care Center, whose certification by DHCS CCS is probationary.

~~5.~~7. If a CMS- or DHCS-approved Transplant Center loses its certification by DHCS or CMS, CalOptima shall have the right to transfer any Members who are awaiting Transplants at such facility.

8. If a DHCS CCS-approved Transplant Special Care Center loses its certification by DHCS CCS, CalOptima ~~and a Health Network~~ shall ~~authorize~~have the right to transfer any Members who are awaiting Transplants at such facility.

B. A DHCS -approved Transplant Center for ~~Medi-Cal Members,~~Bone Marrow, Heart, Lung, Liver or Kidney Transplants is a Special Care Center that:

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a. Provides comprehensive, coordinated health care to CCS clients with specific medical conditions.

b. Meets standards established by DHCS; and

~~a.~~c. Is approved by DHCS to participate in ~~accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.~~the CCS program

~~B.~~C. CalOptima shall process and pay claims for Transplants and related services in accordance with CalOptima Policies FF.1005a: Special Payments – Bone Marrow Transplant and Solid Organ Transplant, and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

~~A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage~~
~~B.~~A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~C.~~B. CalOptima Policy FF.1005a: Special Payments – Bone Marrow Transplant and Solid Organ Transplant
~~D.~~C. 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.~~D. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
E. CalOptima Policy GG.1101: Whole Child Model / California Children's Services
F. CalOptima Memorandum of Understanding with California Children's Services
~~G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~H.~~G. CalOptima Utilization Management Program
H. Department of Health Care Services All Plan Letter 18-023: California Children's Services Whole Child Model
I. Department of Health Care Services Operating Instruction Letter 139-06, Pancreas Transplants
J. Title 22, California Code of Regulations (CCR~~.),~~), §§51003 and 51218
K. Welfare and Institutions Code, §§14132.69, 14132.70, 14132.71 and 14133.8

VI. REGULATORY AGENCY APPROVAL(S)

A. 02/24/16: Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

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~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	07/01/1995	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	01/01/2007	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	11/01/2015	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal

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IX. GLOSSARY

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Term	Definition
Bone Marrow Transplant	A procedure in which a patient's bone marrow is destroyed by chemotherapy or radiotherapy and replaced with new bone marrow from a Donor. The Donor may be the patient (autologous), a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated donor (MUD) with human histocompatibility antigens (HL-A) that meet the Department of Health Care Services (DHCS) standards.
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.
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 Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
DHCS-approved Transplant Center	Facilities that are approved by the Department of Health Care Services (DHCS) to provide specific Transplant services. For renal transplants, a DHCS-approved Transplant Center is a facility that: 1. Is certified for, and participates in, the Medicare program: and 2. Meets standards established by DHCS and is certified by DHCS to participate in the Medi-Cal program.
Donor	For the purposes of this policy, refers to an individual who undergoes a surgical operation for the purpose of donating a body organ or human tissue or cells for Transplant.

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Term	Definition
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	An enrollee-beneficiary of a CalOptima program.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combine liver and small bowel; or 9. Combined kidney and pancreas
Transplant	A non-experimental procedure for human tissue or organ Transplant.

~~IX.I. GLOSSARY~~

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Term	Definition
Bone Marrow Transplant	A procedure in which a patient's bone marrow is destroyed by chemotherapy or radiotherapy and replaced with new bone marrow from a Donor. The Donor may be the patient (autologous), a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated donor (MUD) with human histocompatibility antigens (HL-A) that meet the Department of Health Care Services (DHCS) standards.
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.
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 Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
DHCS-approved Transplant Center	Facilities that are approved by the Department of Health Care Services (DHCS) to provide specific Transplant services. For renal transplants, a DHCS-approved Transplant Center is a facility that: 1. Is certified for, and participates in, the Medicare program: and 2. Meets standards established by DHCS and is certified by DHCS to participate in the Medi-Cal program.
Donor	For the purposes of this policy, refers to an individual who undergoes a surgical operation for the purpose of donating a body organ or human tissue or cells for Transplant.

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~~Medically Necessary or Medical Necessity~~	~~Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.~~
~~Member~~	~~An enrollee beneficiary of a CalOptima program.~~
~~Solid Organ Transplant~~	~~A Transplant for:~~ ~~Heart;~~ ~~Heart and lung;~~ ~~Lung;~~ ~~Liver;~~ ~~Small bowel;~~ ~~Kidney;~~ ~~Combined liver and kidney;~~ ~~Combine liver and small bowel; or~~ ~~Combined kidney and pancreas~~
~~Transplant~~	~~A non-experimental procedure for human tissue or organ Transplant.~~
~~Transplant Center~~	~~For the purposes of this policy, refers to facilities that are approved by the California Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid (CMS) to provide specific transplant services.~~

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Policy #:	GG.1105
Title:	**Coverage of Organ and Tissue Transplants**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/1995
Revised Date:	TBD

FOR 2019 12-05 BOD REVIEW

I. PURPOSE

This policy defines Transplant coverage for CalOptima Members under the Medi-Cal program.

II. POLICY

A. A Transplant shall be a Covered Service if a Member meets the patient selection criteria as defined in Section II.B. of this policy:

1. A Transplant shall be a Covered Service if a Member is twenty-one (21) years of age or older.

2. Effective July 1, 2019, a Transplant shall be a Covered Service for Members eligible with the Whole-Child Model (WCM) program.

B. Selection Criteria

1. A Transplant shall be a Covered Service upon CalOptima's or a Health Network's determination that the Member is a candidate for a Transplant, is compliant with all requirements, and does not have significant contraindications for the Transplant as follows:

   a. Except for Members enrolled in a Health Maintenance Organization (HMO) that is responsible for all Covered Services for its assigned Members under its contract with CalOptima, CalOptima shall be responsible for the provision and payment of Covered Services related to the Transplant, including but not limited to evaluation of potential Donors and procurement from living or deceased Donors in accordance with this Policy and CalOptima Policies GG.1313: Coordination of Care for Transplant Members, FF.1005a Special Payments – Bone Marrow Transplant and Solid Organ Transplant and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. A Transplant and related services shall be Covered Services if:

   a. A Provider or Practitioner obtains authorization for these services from CalOptima in accordance with CalOptima Policies GG.1500 Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, GG.1508 Authorization and Processing of Referrals and GG.1535 Utilization Review Criteria and Guidelines;

   b. The Transplant is performed in an approved facility, as set forth in Section III.A. of this policy; and

   c. The Member is accepted at the approved facility for the following Transplants:

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i. Heart;

ii. Heart and lung;

iii. Lung;

iv. Bone marrow;

v. Liver;

vi. Small bowel;

vii. Kidney;

viii. Pancreas;

ix. Combined liver and kidney;

x. Combined liver and small bowel;

xi. Combined kidney and pancreas; and/or

xii. Cornea, skin, tendon and sclera transplants.

4. Renal Transplants

a. A renal Transplant and related services are Covered Services if the Transplant is performed at a DHCS-approved Transplant Center.

b. A renal Transplant and related services are Covered Services for Members with a CCS-eligible condition if the Transplant is performed at a DHCS-approved Special Care Renal Dialysis and Transplant Center.

c. CalOptima shall consider the selection criteria for a renal Transplant as met if CalOptima determines that the Transplant is Medically Necessary, in accordance with Title 22, California Code of Regulations (CCR.), Sections 51003 and 51218.

d. CalOptima is responsible for the provision of all services related to a renal Transplant including, but not limited to, evaluation of potential Donors and nephrectomy from living, or deceased, Donors.

5. Cornea, Skin, Tendon, and Sclera Transplants

a. A Transplant and related services for cornea, skin, tendon, and sclera are Covered Services if the Transplant is performed at a Medi-Cal facility or at a designated Special Care Center for Members with a CCS-eligible condition.

b. CalOptima shall consider the selection criteria for such Transplants as met if CalOptima determines that the Transplant is Medically Necessary, in accordance with Title 22, California Code of Regulations (CCR), Section 51003.

III. PROCEDURE

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A. DHCS-approved Transplant Centers and CCS-approved Transplant Special Care Centers

1. A DHCS-approved Transplant Center is a facility that is approved by DHCS to provide specific Transplant services for Medi-Cal Members.

2. A CCS-approved Transplant Center for all Transplants is a Special Care Center that is approved by DHCS, to provide specific Transplant Services for CCS WCM-eligible Members as determined by CCS in accordance with CalOptima Policy GG.1101: Whole-Child Model / California Children's Services.

3. A DHCS-approved Transplant Center for a renal Transplant for a renal Transplant is a facility that:

   a. Is certified for, and participates in, the Medicare program;

   b. Meets standards established by CMS or DHCS; and

   c. Is certified by DHCS, to participate in the Medi-Cal program.

4. CalOptima or a Health Network shall identify a DHCS CCS-approved Transplant Special Care Center based upon information, documentation and representation received from DHCS and CCS.

5. CalOptima's Chief Medical Officer (CMO) or Designee shall have the authority to determine CalOptima coverage of a Transplant performed at a DHCS-approved Transplant Center, whose certification by DHCS is probationary.

6. CalOptima's Chief Medical Officer (CMO) or Designee shall have the authority to determine CalOptima coverage of a Transplant performed at a DHCS- and CCS-approved Transplant Special Care Center, whose certification by DHCS CCS is probationary.

7. If a CMS- or DHCS-approved Transplant Center loses its certification by DHCS or CMS, CalOptima shall have the right to transfer any Members who are awaiting Transplants at such facility.

8. If a DHCS CCS-approved Transplant Special Care Center loses its certification by DHCS CCS, CalOptima shall have the right to transfer any Members who are awaiting Transplants at such facility.

B. A DHCS -approved Transplant Center for Bone Marrow, Heart, Lung, Liver or Kidney Transplants is a Special Care Center that:

   a. Provides comprehensive, coordinated health care to CCS clients with specific medical conditions.

   b. Meets standards established by DHCS; and

   c. Is approved by DHCS to participate in the CCS program

C. CalOptima shall process and pay claims for Transplants and related services in accordance with CalOptima Policies FF.1005a: Special Payments – Bone Marrow Transplant and Solid Organ Transplant, and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-

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

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy FF.1005a: Special Payments – Bone Marrow Transplant and Solid Organ Transplant
C. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
D. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
E. CalOptima Policy GG.1101: Whole Child Model / California Children's Services
F. CalOptima Memorandum of Understanding with California Children's Services
G. CalOptima Utilization Management Program
H. Department of Health Care Services All Plan Letter 18-023: California Children's Services Whole Child Model
I. Department of Health Care Services Operating Instruction Letter 139-06, Pancreas Transplants
J. Title 22, California Code of Regulations (CCR), §§51003 and 51218
K. Welfare and Institutions Code, §§14132.69, 14132.70, 14132.71 and 14133.8

VI. REGULATORY AGENCY APPROVAL(S)

A. 02/24/16: Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/1995	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	01/01/2007	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	11/01/2015	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal

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IX. GLOSSARY

Term	Definition
Bone Marrow Transplant	A procedure in which a patient's bone marrow is destroyed by chemotherapy or radiotherapy and replaced with new bone marrow from a Donor. The Donor may be the patient (autologous), a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated donor (MUD) with human histocompatibility antigens (HL-A) that meet the Department of Health Care Services (DHCS) standards.
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.
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 Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
DHCS-approved Transplant Center	Facilities that are approved by the Department of Health Care Services (DHCS) to provide specific Transplant services. For renal transplants, a DHCS-approved Transplant Center is a facility that: 1. Is certified for, and participates in, the Medicare program: and 2. Meets standards established by DHCS and is certified by DHCS to participate in the Medi-Cal program.
Donor	For the purposes of this policy, refers to an individual who undergoes a surgical operation for the purpose of donating a body organ or human tissue or cells for Transplant.

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Term	Definition
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	An enrollee-beneficiary of a CalOptima program.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combine liver and small bowel; or 9. Combined kidney and pancreas
Transplant	A non-experimental procedure for human tissue or organ Transplant.

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Policy:	MA.6044
Title:	**Coverage of Solid Organ and Stem Cell Transplants**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader
Effective Date:	12/05/2019
Revised Date:	Not Applicable
Applicable to:	☒ OneCare ☒ OneCare Connect

FOR 20191205BOD REVIEW

I. PURPOSE

This policy defines the coverage of **Solid Organ** and **Stem Cell Transplants** and related care and services for CalOptima **Members** in the OneCare and OneCare Connect Programs.

II. POLICY

A. A **Solid Organ** or **Stem Cell Transplant** shall be a **Covered Service** upon CalOptima's or a **Health Network's** determination that the **Member** is a candidate for a **Transplant**, is compliant with all requirements, and does not have significant contraindications for the **Transplant**.

B. CalOptima or a **Health Network** shall be responsible for the provision and payment of **Covered Services** related to a **Transplant** including the following:

1. Pre-transplant evaluation, including physician, psychological and social work consultations, necessary lab work and imaging;

2. Evaluation of potential **Donors** and organ/stem cell procurement fees;

3. **Transplant** care, including inpatient facility and professional fees:

4. Post-transplant care, including **Medically Necessary** immunosuppressant drugs.

C. A **Solid Organ** or **Stem Cell Transplant** and related services shall be **Covered Services** if:

1. A **Provider** or **Practitioner** obtains prior authorization for these services from CalOptima or a **Health Network** in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals. The **Transplant** meets **Medically Necessity** and utilization review criteria and guidelines for coverage of the **Solid Organ** or **Stem Cell Transplant** and related services as described in CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines.

2. The **Transplant** is performed at an approved facility, as set forth in Section III.A. of this policy; and

3. The **Member** is accepted at the approved facility for the following **Transplants**

   a. Heart;

   b. Lung;

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

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c. Heart/Lung;

d. Kidney;

e. Pancreas;

f. Kidney/Pancreas;

g. Liver;

h. Intestine;

i. Liver/Intestine; and

j. Stem Cell.

D. CalOptima or a **Health Network** shall not approve the following **Transplants**:

1. **Transplants** that are experimental/investigational in nature, unless in a qualified Medicare-approved clinical trial;

2. Combined kidney and liver **Transplant**;

3. Pancreas **Transplant** for diabetic **Members** who have not experienced end stage renal failure secondary to diabetes;

4. Partial pancreatic tissue transplantation;

5. Adult liver transplantation for malignancies (excluding hepatocellular carcinoma); and

6. Nationally non-covered indications in the respective National Coverage Determinations.

E. Routine costs for Investigational Services associated with a Clinical Trial may be covered by CalOptima or a **Health Network** in accordance with CalOptima Policy GG.1102: Experimental and Investigational Service Coverage.

F. CalOptima or a **Health Network** shall provide notification on decisions for services requiring prior authorization in accordance with CalOptima Policy GG.1507: Notification Requirements for **Covered Services** Requiring Prior Authorization**.**

G. When CalOptima or a **Health Network** authorize a **Member** to receive a **Transplant** outside of CalOptima's **Service Area**, CalOptima or a **Health Network** shall cover reasonable expenses for transportation to and lodging at the distant location for the **Member** and a companion.

H. **Transplants** not covered under OneCare or OneCare Connect programs, may be covered under the CalOptima Medi-Cal program as set forth in CalOptima Policy GG.1105: Coverage of Organ and Tissue **Transplants**.

III. PROCEDURE

A. **Centers for Medicare & Medicaid Services (CMS)**-approved **Transplant** Centers

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1. A **Transplant** must be performed in a **CMS**-approved **Transplant** Center for that specific **Transplant** type; as required by **CMS** and the decision based on Medicare coverage criteria, including national and local coverage determinations (NCDs and LCDs)

2. CalOptima or a **Health Network** shall identify a **CMS**-approved **Transplant Center**, based upon information, documentation, and representation received from **CMS**.

3. CalOptima or a **Health Networks'** Chief Medical Officer (CMO) or **Designee** shall have the authority to determine coverage of a **Transplant** performed at a **CMS**-approved **Transplant Center**, whose certification by **CMS** is probationary.

4. If a **CMS**-approved **Transplant** Center loses its certification by **CMS**, CalOptima shall have the right to transfer any **Members** who are awaiting Transplants at such facility.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Policy GG.1102: Experimental and Investigational Service Coverage
D. CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants
E. CalOptima Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
G. CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines
H. CalOptima Utilization Management Program

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/05/2019	MA.6044	Coverage of Solid Organ and Stem Cell Transplants	OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Donor	For the purposes of this policy, refers to an individual who undergoes a surgical operation for the purpose of donating a solid organ or stem cells for Transplant.
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	An enrollee-beneficiary of a CalOptima program.
Practitioner	OneCare: A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services as described in OneCare Policies. OneCare Connect: A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services as described in OneCare Connect Policies.

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Term	Definition
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.
Service Area	The geographical area that DHCS and/authorizes CalOptima to operate in. A Service Area may include designated ZIP Codes within a county that CalOptima is approved to operate in.
Stem Cell Transplant	A process which includes mobilization, harvesting, and transplant of peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant.
Transplant	A non-experimental procedure for Solid Organ or Stem Cell Transplant.
Transplant Center	For the purposes of this policy, refers to facilities that are approved by the Centers for Medicare & Medicaid (CMS) to provide specific transplant services.

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Medi-Cal CalOptima A Public Agency Better. Together.

Policy ~~#~~:	GG.1327
Title:	**Coordination ~~of Care Plans~~ for Dual-Eligible Members, Not Enrolled in ~~Long Term Services and Supports (~~OneCare Connect, with LTSS~~) Programs~~**
Department:	Medical Affairs
Section:	Long Term Services and Supports (LTSS)
CEO Approval:	Michael Schrader
Effective Date:	07/01/2015
~~Last~~ Revised Date:	~~10/10/17~~TBD

For 20191205BOD Review

I. PURPOSE

This policy describes the process for ~~coordinating care plans for Full Benefit Dual Eligible Members Excluded from, or opting out of, OneCare Connect, or Partial Dual Eligible Members enrolled in~~ reviewing **Long Term Services and Supports (LTSS)** ~~programs.~~ assessments and **Individualized Care Plans (ICP)*** for dual-eligible **Members** who are enrolled in **LTSS** programs and not

~~II. POLICY~~

~~A.~~ ~~CalOptima shall ensure care coordination for Members~~ enrolled in ~~Long Term Services and Supports (LTSS) programs.~~OneCare Connect (OCC), including **Members** who opt out of OCC, **Members** who are full benefit dual-eligible **Members** excluded from OCC, or **Members** who are partially dual-eligible.

II. POLICY

~~B.~~A. **CalOptima** shall risk stratify ~~a~~ newly-enrolled ~~**Member who opts out of OneCare Connect, is a Full Benefit Dual Eligible excluded from OneCare Connect, or a Partial Dual Eligible**~~**Dual-Eligible Members** not enrolled in OCC, in accordance with CalOptima Policy GG.1326: Risk Stratification Process for a Member who Opts Out of **Cal MediConnect**, or is a **Full Benefit Dual-Eligible** excluded from **Cal MediConnect**, or is a **Partial Dual-Eligible**~~, and shall complete the following:~~. For such **Members** with **LTSS** and stratified as high-risk, **CalOptima** is not required to complete a~~n~~ **Health Risk Assessment (HRA)** or an **ICP** because **CalOptima** does not have responsibility for the full spectrum of health care services for these **Members**. **CalOptima** shall review assessments and **ICPs** completed in **LTSS** programs instead for care coordination needs, as outlined in this P~~p~~olicy.

~~1. For Members considered OneCare Connect opt-outs, Full Benefit Dual Eligibles who are excluded from OneCare Connect, and Partial Benefit Dual Eligibles:~~

~~a. CalOptima shall complete an LTSS Assessment Review.~~

~~i. CalOptima shall not be required to complete a Health Risk Assessment (HRA), develop an Individual Care Plan (ICP), or convene an Interdisciplinary Care Team (ICT).~~

~~For~~

* Terms in bold are defined in the Glossary.

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~~2. Medi-Cal only Seniors and Persons with Disabilities (SPD) (high risk Members only):~~

~~a. CalOptima shall conduct an HRA when applicable, or when requested by the Member, in accordance with CalOptima Policy GG.1323: Senior and Persons with Disabilities and Health Risk Assessment Policy;~~

~~b. Develop an Individual Care Plan (ICP); and~~

~~c. Establish an Interdisciplinary Care Team (ICT) when appropriate, or when requested by the Member, in accordance with GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management.~~

~~i. CalOptima shall not complete an LTSS Assessment Review for SPD Members~~

~~C. CalOptima shall document, maintain, and review a copy of a Member's assessment records and ICP, when applicable, for Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS) center, or a skilled nursing facility, and that are received from California Department of Social Services (CDSS) for In-Home Supportive Services (IHSS), as applicable, to determine if further coordination of services for the Member is appropriate.~~

III. PROCEDURE

A. **Long~~-~~Term Services and Supports (LTSS)** Assessment and **Individualized Care Plan (ICP)** Review

1. Upon enrollment of a ~~**Member who opts out of Cal MediConnect, or is a Full Benefit**~~ **Dual-Eligible** ~~**excluded from Cal MediConnect, or is a Partial Dual-Eligible**~~**Members** not enrolled in OCC and stratified as high-risk due to participation in an **LTSS** program, **CalOptima** shall obtain ~~assessments conducted~~ available assessment(s) and **ICP(s)** completed on the **Member's** behalf through **MSSP**, **CBAS**, **SNF**, and **IHSS**~~, MSSP, and nursing facilities.~~ .

2. ~~**Based on the completed and available assessments,**~~ **CalOptima** shall review the **LTSS** ~~Assessment~~assessment(s) and **ICP(s)**, at least annually, and determine if any further coordination of services ~~for the Members~~ is appropriate, such as, but not limited to:

a. ~~Carved-out or home and community-based services,~~Referrals for appropriate community resources~~, and available services and benefits~~ and other agencies outside the scope of **CalOptima's** responsibility that meet ~~**the**~~ **Member's** social, and transportation needs and preferences, including but not limited to:

i. Mental health and behavioral health ~~services~~;

ii. Personal care;

iii. Housing;

iv. Home-delivered meals;

v. Energy assistance programs; and

vi. Services for **Members** with intellectual and developmental disabilities.

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b. ~~Assessment of~~ Involving caregivers in the **Member's** ~~support systems, caregiver resources, and level of involvement to identify~~care, which includes identifying **Member** and caregiver preferences and ~~alternate arrangements should a caregiver be~~having back-up plans in place for situations when caregivers are unavailable;

c. ~~Evaluation of Member's current health status and treatment needs and the need for facilitating~~Facilitating communication among the **Member's LTSS** and other providers, including mental health and substance abuse providers, ~~as~~when appropriate~~;~~ given **Member's** health status and treatment needs; and

~~d. Identification and facilitation of~~ Providing referrals for ~~Members who require referrals to disease management program, health education, case management, counseling,~~other activities or ~~self-management support, including~~ services ~~outside CalOptima's provider network;~~

~~e. Ensuring assessment, reassessment, and referrals are completed as~~ needed ~~for a Member's~~ to assist **Members** in optimizing their health status ~~under the following circumstances:~~

~~i. With changes to Member's health status;~~

~~ii. When there's identification of physical and cognitive barriers;~~

~~iii. When a Member requires:~~

~~a) Referrals for Primary Care and Specialty Providers;~~

~~b) Mental health and substance abuse providers;~~

~~c)~~d. ~~Assistance~~, including assistance with self-~~-~~management skills or techniques~~;~~, health education, Health Homes Program, Whole Person Care Program, and other modalities to improve health status and meet personal goals.

~~d) Assistance with health education; and~~

~~e) Other methods for improving health status.~~

~~f. At least annual review of LTSS Assessment(s).~~

e. Re-contacting or reassessing the **Member** due to additional or unalleviated risks in **Member's** circumstances or conditions that require redetermination of risk level through **Risk Stratification**.

B. Coordination of Care and Services

1. **CalOptima** shall ~~determine if Members need other~~ complete referrals for appropriate community ~~based~~ resources and other agencies, facilitate communication among providers, or provide other activities or services~~, or other medical services,~~ to optimize health status, if determined to be appropriate based on the **LTSS** ~~Assessment Reviews and clinical knowledge of the Member's needs.~~ assessment(s) and **ICP(s)** reviewed.

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2. **CalOptima** shall refer Members to appropriate levels of care and community-based services (IHSS, CBAS, and/or MSSP), hospital, or institution (LTC) that meets each Member's medical and social needs.

3. For Members who are receiving LTSS services, and upon request by the Member or CalOptima or Health Network case managers, the IHSS Social Worker and/or CBAS provider, LTC case manager, and/or MSSP case manager shall participate in the Member's ICT meeting.

4.2. CalOptima, or a Health Network, shall document care coordinationcompleted activities and interventions in the medical management system.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1323: Senior and Persons with Disabilities and Health Risk Assessment Policy
C. CalOptima Policy GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management
D. CalOptima Policy GG.1326: Risk Stratification Process for a Member who Opts Out of Cal MediConnect, or is a Full Benefit Dual-Eligible excluded from Cal MediConnect or is a Partial Dual-Eligible
E. Medi-Cal ManagedDepartment of Health Care DivisionServices All Plan Letter (APL) 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports
F. Medi-Cal ManagedDepartment of Health Care DivisionServices All Plan Letter (APL) 17-013: Requirements for the Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities
F.G. Department of Health Care Services All Plan Letter (APL) 18-012: Health Homes Program Requirements

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/21/2015	Department of Health Care Services (DHCS)

A. 05/21/15: Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting
11/07/2019	Regular Meeting of the CalOptima Board of Directors

None to Date

VIII. REVIEW/REVISION HISTORY

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~~Version~~ Action	Date	~~Policy Number~~Policy	Policy Title	~~Line(s) of Business~~Program(s)
Effective	07/01/2015	GG.1327	Coordination of Care Plans for Members Enrolled in Long-Term Services and Supports (LTSS) Programs	Medi-Cal
Revised	10/01/2016	GG.1327	Coordination of Care Plans for Members Enrolled in Long-Term Services and Supports (LTSS) Programs	Medi-Cal
Revised	10/01/2017	GG.1327	Coordination of Care Plans for Members Enrolled in Long-Term Services and Supports (LTSS) Programs	Medi-Cal
Revised	TBD	GG.1327	Coordination of Care Plans for Dual-Eligible Members, Not Enrolled in Long Term Services and Supports (OneCare Connect, with LTSS	Medi-Cal

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IX. GLOSSARY

Term	Definition
Cal MediConnect	A three-year Duals Demonstration project (Cal MediConnect) for dual-eligibles that combines the full continuum of acute, primary, institutional, and home and community-based services into a single benefit package, delivered through an organized service delivery system.
CalOptima	For purposes of this policy, CalOptima means CalOptima Direct (COD) and CalOptima Community Network (CCN).
Comprehensive Medical Case Management	Services provided by a Primary Care Provider, in collaboration with CalOptima or a Health Network to ensure the coordination of Medically Necessary health care services, the provision of preventive services, in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
Community-Based Adult Services (CBAS)	An outpatient program that delivers Skilled Nursing Facility care, social services, therapies, personal care, family/caregiver training and support, nutritional services, transportation, and other services to eligible Members who meet applicable eligibility criteria.
Full Benefit Dual Eligible Member Excluded from OneCare Connect	A Member who is eligible for Medicare Parts A, B, and D, and Full-Scope Medi-Cal but is ineligible for Cal MediConnect due to exclusion criteria, including Members: 1. With other health coverage, including private insurance and non-Medicare public insurance, such as through the Veterans Administration; 2. With developmental disabilities receiving services through a Department of Developmental Services (DDS) 1915(c) waiver; regional center; state developmental center; or intermediate care facilities for the developmentally disabled (ICF/DD); 3. Enrolled in the following 1915(c) waivers: Nursing facility/acute hospital waiver service, HIV/AIDS waiver services, assisted living waiver services, and In-Home Operations waiver services; and 4. Residing in a veterans' home of California.
Full Benefit Dual Eligible Who Opts Out of OneCare Connect	A Member who is 21 years of age or older and is eligible for Medi-Cal, and who is also eligible for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) and Medicare Part B (42 U.S.C. Sec. 1395j et seq.)
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.
High Risk Member	For the purposes of this policy, means a Member who is receiving: IHSS authorized for greater than or equal to 195 hours per month; Community Based Adult Services (CBAS); and/or Multipurpose Senior Services (MSSP),
In-Home Supportive Services (IHSS)	Services provided for Members in accordance with the requirements set forth in Welfare and Institutions Code section 14186.1(c)(1).
Individual Care Plan (ICP)	A written plan of care developed after an assessment of a Member's social and health care needs that reflects what services the Member will receive to reach and keep his or her best physical, mental, and social well-being.

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Term	Definition
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers, that work with the Member to develop, implement, and maintain the ICP.
Institution	For purposes of this policy: 1. A Skilled Nursing Facility that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, C.C.R. §51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, C.C.R. §51215 (except that the distinct part of a certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program. 2. An Intermediate Care 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, C.C.R § 51212, and has been certified by DHCS for participation in the Medi-Cal program. 3. Subacute Facility –Adult that meets the standards set forth in Title 22, § 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous room, a wing, a floor, or a building that is approved by the Department of Public Health for such purpose and has been certified by the DHCS for participation in the Medi-Cal program. 4. Subacute Facility-Pediatric that meets the standards set forth in Title 22, § 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.
Long–Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 2. Community-Based Adult Services (CBAS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.
Long–Term Care (LTC)	For purposes of this policy, care provided for Members in a Skilled Nursing Facility and subacute care services
Lower Risk Member	For the purposes of this policy, means a Member needing basic care management.
Medi-Cal Only Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the Department of Health Care Services.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

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Term	Definition
Multipurpose Senior Services Program (MSSP)	A program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.
Partial Dual-Eligible	A Member who is 21 years of age or older and is eligible for Medi-Cal, and who is also eligible for benefits under either Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).
Risk Stratification	A systematic process for identifying and predicting Member risk levels relating to health care needs, services, and coordination.

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Policy:	GG.1327
Title:	**Coordination for Dual-Eligible Members, Not Enrolled in OneCare Connect, with LTSS**
Department:	Medical Affairs
Section:	Long Term Services and Supports (LTSS)
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/2015
Revised Date:	TBD

For 20191205 BOD Review

I. PURPOSE

This policy describes the process for reviewing **Long Term Services and Supports (LTSS)** assessments and **Individualized Care Plans (ICP)*** for dual-eligible **Members** who are enrolled in **LTSS** programs and not enrolled in OneCare Connect (OCC), including **Members** who opt out of OCC, **Members** who are full benefit dual-eligible **Members** excluded from OCC, or **Members** who are partially dual-eligible.

II. POLICY

A. **CalOptima** shall risk stratify newly-enrolled **Dual-Eligible Members** not enrolled in OCC, in accordance with CalOptima Policy GG.1326: Risk Stratification Process for a Member who Opts Out of **Cal MediConnect**, or is a **Full Benefit Dual-Eligible** excluded from **Cal MediConnect**, or is a **Partial Dual-Eligible**. For such **Members** with **LTSS** and stratified as high-risk, **CalOptima** is not required to complete a **Health Risk Assessment (HRA)** or an **ICP** because **CalOptima** does not have responsibility for the full spectrum of health care services for these **Members**. **CalOptima** shall review assessments and **ICPs** completed in **LTSS** programs instead for care coordination needs, as outlined in this Policy.

III. PROCEDURE

A. **Long-Term Services and Supports (LTSS)** Assessment and **Individualized Care Plan (ICP)** Review

1. Upon enrollment of a **Dual-Eligible Members** not enrolled in OCC and stratified as high-risk due to participation in an **LTSS** program, **CalOptima** shall obtain available assessment(s) and **ICP(s)** completed on the **Member's** behalf through **MSSP**, **CBAS**, **SNF**, and **IHSS**.

2. **CalOptima** shall review the **LTSS** assessment(s) and **ICP(s)**, at least annually, and determine if any further coordination of services is appropriate, such as, but not limited to:

   a. Referrals for appropriate community resources and other agencies outside the scope of **CalOptima's** responsibility that meet **Member's** social, and transportation needs and preferences, including but not limited to:

      i. Mental health and behavioral health;

      ii. Personal care;

      iii. Housing;

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

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iv. Home-delivered meals;

v. Energy assistance programs; and

vi. Services for **Members** with intellectual and developmental disabilities.

b. Involving caregivers in the **Member's** care, which includes identifying **Member** and caregiver preferences and having back-up plans in place for situations when caregivers are unavailable;

c. Facilitating communication among the **Member's LTSS** and other providers, including mental health and substance abuse providers, when appropriate given **Member's** health status and treatment needs; and

d. Providing referrals for other activities or services needed to assist **Members** in optimizing their health status, including assistance with self-management skills or techniques, health education, Health Homes Program, Whole Person Care Program, and other modalities to improve health status and meet personal goals.

e. Re-contacting or reassessing the **Member** due to additional or unalleviated risks in **Member's** circumstances or conditions that require redetermination of risk level through **Risk Stratification**.

B. Coordination of Care and Services

1. **CalOptima** shall complete referrals for appropriate community resources and other agencies, facilitate communication among providers, or provide other activities or services to optimize health status, if determined to be appropriate based on the **LTSS** assessment(s) and **ICP(s)** reviewed.

2. **CalOptima** shall document completed activities in the medical management system.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1323: Senior and Persons with Disabilities and Health Risk Assessment Policy
C. CalOptima Policy GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management
D. CalOptima Policy GG.1326: Risk Stratification Process for a Member who Opts Out of Cal MediConnect, or is a Full Benefit Dual-Eligible excluded from Cal MediConnect or is a Partial Dual-Eligible
E. Department of Health Care Services All Plan Letter (APL) 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports
F. Department of Health Care Services All Plan Letter (APL) 17-013: Requirements for the Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities

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G. Department of Health Care Services All Plan Letter (APL) 18-012: Health Homes Program Requirements

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/21/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
11/07/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2015	GG.1327	Coordination of Care Plans for Members Enrolled in Long-Term Services and Supports (LTSS) Programs	Medi-Cal
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Revised	TBD	GG.1327	Coordination of Care Plans for Dual-Eligible Members, Not Enrolled in Long Term Services and Supports (OneCare Connect, with LTSS	Medi-Cal

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IX. GLOSSARY

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Full Benefit Dual Eligible Member Excluded from OneCare Connect	A Member who is eligible for Medicare Parts A, B, and D, and Full-Scope Medi-Cal but is ineligible for Cal MediConnect due to exclusion criteria, including Members: 1. With other health coverage, including private insurance and non-Medicare public insurance, such as through the Veterans Administration; 2. With developmental disabilities receiving services through a Department of Developmental Services (DDS) 1915(c) waiver; regional center; state developmental center; or intermediate care facilities for the developmentally disabled (ICF/DD); 3. Enrolled in the following 1915(c) waivers: Nursing facility/acute hospital waiver service, HIV/AIDS waiver services, assisted living waiver services, and In-Home Operations waiver services; and 4. Residing in a veterans' home of California.
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In-Home Supportive Services (IHSS)	Services provided for Members in accordance with the requirements set forth in Welfare and Institutions Code section 14186.1(c)(1).
Individual Care Plan (ICP)	A written plan of care developed after an assessment of a Member's social and health care needs that reflects what services the Member will receive to reach and keep his or her best physical, mental, and social well-being.

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Term	Definition
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers, that work with the Member to develop, implement, and maintain the ICP.
Institution	For purposes of this policy: 1. A Skilled Nursing Facility that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, C.C.R. §51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, C.C.R. §51215 (except that the distinct part of a certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program. 2. An Intermediate Care 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, C.C.R § 51212, and has been certified by DHCS for participation in the Medi-Cal program. 3. Subacute Facility –Adult that meets the standards set forth in Title 22, § 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous room, a wing, a floor, or a building that is approved by the Department of Public Health for such purpose and has been certified by the DHCS for participation in the Medi-Cal program. 4. Subacute Facility-Pediatric that meets the standards set forth in Title 22, § 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.
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Lower Risk Member	For the purposes of this policy, means a Member needing basic care management.
Medi-Cal Only Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the Department of Health Care Services.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

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Term	Definition
Multipurpose Senior Services Program (MSSP)	A program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.
Partial Dual-Eligible	A Member who is 21 years of age or older and is eligible for Medi-Cal, and who is also eligible for benefits under either Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).
Risk Stratification	A systematic process for identifying and predicting Member risk levels relating to health care needs, services, and coordination.

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For 20191205BOD Review

Policy ~~#~~: GG.1423
Title: **Medication Quality Assurance Program**
Department: Medical Affairs
Section: Pharmacy Management

CEO Approval: Michael Schrader _____

Effective Date: 06/07/2011
~~Last Review Date:~~ ~~01/01/18~~
~~Last~~ Revised Date: ~~01/01/18~~TBD

For 20191205BOD Review

I. PURPOSE

This policy establishes a quality assurance program to reduce medication errors and adverse drug interactions, and improve medication use through prospective and retrospective drug utilization review (DUR).

II. POLICY

A. CalOptima shall ensure that **Participating Pharmacies*** comply with the minimum standards for pharmacy practice as established by California in accordance with the California Business and Professions Code, Section 4000 *et. seq*.

B. CalOptima or its **Pharmacy Benefit Manager (PBM)** shall maintain quality assurance measures and systems including:

1. Prospective drug utilization review (DUR) systems;

2. Retrospective drug utilization review (DUR) systems; and

3. Internal medication error identification and reduction systems.

C. CalOptima shall provide information to the Department of Health Care Services (DHCS) regarding its quality assurance measures and systems pertaining to improving medication use, reducing medication errors, and adverse drug interactions.

D. CalOptima shall provide Members access to view their drug profile and to perform drug formulary validation in accordance with CalOptima Policy GG.1424: Pharmacy Benefit Information for Members.

E. CalOptima shall perform medication reconciliation in accordance with CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply.

~~D.~~F. CalOptima shall establish systems and measures to ensure that **Participating Pharmacies** comply with CalOptima's quality assurance requirements.

~~E.~~G. The **PBM** shall ensure that **Participating Pharmacies** offer patient counseling to Members, when appropriate, in accordance with state law.

H. Electronic Prescription Drug Program .

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

1. The **PBM** shall support electronic prescribing in accordance with applicable federal and state laws, regulations and standards, including, without limitations, Subpart D of 42 CFR Part 423.

2. The **PBM** shall establish and maintain an electronic prescription drug program that complies with applicable standards, including, without limitations, 42 CFR § 423.160(b), when transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media for Members.

3. The **PBM** shall ensure that all necessary contracts and systems are in place should prescribing health care practitioners desire to electronically transmit prescriptions for Members. The PBM shall ensure that **Participating Pharmacies**:

   a. Can receive electronic prescriptions (with allowance for exceptions when it is impractical or otherwise could jeopardize beneficiary access) in accordance with applicable standards. The **PBM** shall have an approval process for such exceptions and a process to redirect prescribing health care practitioners to appropriate alternate **Participating Pharmacies**.

   b. Process electronic prescriptions received from prescribing health care practitioners, when appropriate, in accordance with all applicable federal and state laws, regulations, and standards.

   c. Immediately notify the prescribing health care practitioner when the **Participating Pharmacy**, or its staff, is aware that an attempted transmission of an electronic prescription failed, is incomplete, or otherwise not properly received.

~~F.~~I. **Participating Pharmacies** shall implement a method to keep Member information records and maintain up-to-date Member information including, but not limited to:

1. Member demographic information; and

2. Member allergy information including drug and food allergies.

~~G.~~J. CalOptima shall make efforts toward including the following in quality assurance systems:

1. Electronic prescribing;

2. Clinical decision support systems;

3. Educational interventions;

4. Adverse event reporting systems; and

5. Provider and Member education.

~~H.~~K. Effective July 1, 2017, CalOptima shall participate in a global Medi-Cal DUR program. The global Medi-Cal DUR program will assess data on drug use against predetermined standards, consistent with the following:

1. Compendia, which shall consist of the following:

   a. American Hospital Formulary Service Drug Information;

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b. United States Pharmacopeia-Drug Information (or its successor publications);

c. The DrugDex Information System; and

2. Peer-reviewed medical literature.

~~I.~~L. CalOptima shall include the participation with the Medi-Cal DUR Board as part of its DUR Program activities.

1. CalOptima shall actively participate directly in the Medi-Cal DUR Board by means of the California Association of Health Plans.

2. On a quarterly basis, CalOptima shall assess the Medi-Cal DUR Board's recommendations and decide if it will adopt their recommendations or not. If CalOptima chooses not to adopt certain recommendations, a justification shall be provided to DHCS as part of the annual DUR report outlined in Section II.~~K~~N of this policy.

~~J.~~M. CalOptima shall provide educational efforts and outreach programs, in collaboration with the Medi-Cal DUR Board, to improve the ability of physicians and pharmacists to identify patterns, and reduce the frequency, of fraud, abuse, misuse, and clinically inappropriate or medically unnecessary care. In addition to these educational outreach programs, CalOptima shall also distribute additional educational materials or articles based on the demographics and trends specific to Member and Provider populations.

~~K.~~N. CalOptima shall submit a detail DUR report to DHCS, in a format specified by DHCS, on its DUR Program activities by April 1 of each year. The report shall include information related to the methodology by which CalOptima meets the requirements for the prospective and retrospective DUR. In addition, CalOptima shall also provide in its annual DUR report any educational programs provided outside of the global educational activities, the rationale for not implementing DUR Board recommended actions, and any other DUR related activities performed outside of the global DUR activities, as applicable.

III. PROCEDURE

A. A **Participating Pharmacy** shall conduct prospective DUR to ensure review of the prescribed drug therapy prior to dispensing or delivering a prescription to a Member. The prospective drug utilization review shall include, but not be limited to:

1. Screening for potential drug therapy problems due to therapeutic duplication;

2. Ingredient duplication;

3. Age and gender-related drug utilization;

4. Drug-to-drug interactions, including serious interactions with non-prescription or over-the-counter drugs;

5. Incorrect drug dosage, such as low or high dose, or duration of drug therapy;

6. Drug-disease contraindications;

7. Drug pregnancy precautions;

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8. Drug-allergy contraindications; and

9. Clinical abuse or misuse.

B. CalOptima shall conduct retrospective DUR on a monthly basis to ensure ongoing examination of claims data and other records through computerized drug claims processing and information retrieval systems to:

1. Identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among **Prescribing Providers, Participating Pharmacies**, and Members; and

2. Identify fraud and abuse patterns associated with specific drugs or groups of drugs.

C. The Pharmacy Management Department shall conduct retrospective DUR using the following methods which include, but are not limited to:

1. Claims oversight for the following:

a. Claims for Medi-Cal FFS carve out medications;

b. Claims for Medicare Part D-covered drugs for dual-eligible members;

c. Over the counter drugs processed for members in Long-Term-Care Facilities;

d. Acetaminophen products for adults over twenty-one (21) years of age;

e. Over the counter cough and cold products for adults over twenty-one (21) years of age;

f. Claims payment for members who are deceased;

g. Members with paid claims from out of state pharmacies;

h. Claims with member copayments;

i. Compounding claims with incorrect level of effort codes;

j. Claims with incorrect dispensing fees; and

k. Claims with incorrect quantities.

2. Members with potential over-utilization of pharmaceuticals as identified through:

a. The **Polypharmacy** Management Program;

b. The **Pharmacy Home Program**; and

c. The Prescriber Restriction Program.

3. Identify Members with potential over-utilization of controlled substances.

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4. Members with potential under-utilization of pharmaceuticals as identified through the following reports:

   a. Members with ~~Diabetes~~diabetes and not receiving a statin;

   b. Members with cardiovascular disease not receiving a statin; and

   c. Members hospitalized for an acute myocardial infarction not receiving persistent beta-blocker treatment for six (6) months after discharge.

5. For Members identified with over- or under-utilization of pharmaceuticals, CalOptima Pharmacy Management Department shall outreach to the Member's Primary Care Physician (PCP) with recommendations to either remove or add additional therapy to the Member's drug regimen. The result of this outreach shall be tracked and reported quarterly at the Pharmacy and Therapeutics (P&T) Committee Meetings.

6. Other programs relating to the **Health Effectiveness Data and Information Set (HEDIS)**.

D. The Pharmacy Management Department shall refer all potential drug-related Quality of Care issues to the Quality Improvement Department for follow-up.

E. CalOptima shall utilize the Food and Drug Administration (FDA) Medwatch form for reporting adverse events and shall educate Providers about the availability of the Medwatch form.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1408: Pharmacy Audits and Reviews
C. CalOptima Policy GG.1413: Polypharmacy Management
D. CalOptima Policy GG.1416: Pharmacy Home Program
E. CalOptima Policy GG.1611: Potential Quality Issue Review Process
F. CalOptima Policy GG.1424: Pharmacy Benefit Information for Members.
G. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
~~F.~~H. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-008: Requirement to Participate in the Medi-Cal Drug Utilization Review Program
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements
J. Health Homes Program Guide
K. Business and Professions Code, §§ 688 and 4070-4072
L. Health and Safety Code §§ 11164-11164.5
M. Title 16, California Code of Regulations (C.C.R.), § 1717.4
N. Title 21, Code of Federal Regulations (C.F.R.), § 1311.200
~~G. Section 1927(g) of the Social Security Act (SSA)~~
~~H.~~O. Title 42, Code of Federal Regulations (C.F.R.), Part 456, Subpart K
~~I.~~P. Title 42, Code of Federal Regulations (C.F.R.), ~~§~~§§ 423.159, 423.160, and 438.3(s)(4)-(5)
Q. Section 1927(g) of the Social Security Act (SSA)

VI. REGULATORY AGENCY APPROVAL(S)

For 20191205BOD Review

A. 06/12/17: Department of Health Care Services
B. 08/09/16: Department of Health Care Services
C. 08/21/14: Department of Health Care Services

VII. BOARD ACTION(S)

~~None to Date~~A. 09/05/2019: Regular Meeting of the CalOptima Board of Directors

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	06/07/2011	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	01/01/2012	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	05/01/2014	GG.1423	Medication Quality Assurance Program	Medi-Cal
Reviewed	10/01/2015	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	06/01/2016	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	07/01/2017	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	01/01/2018	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	TBD	GG.1423	Medication Quality Assurance Program	Medi-Cal

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IX. GLOSSARY

Term	Definition
Healthcare Effectiveness Data and Information Set (HEDIS™):	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Participating Pharmacy	Any pharmacy that is credentialed by and subcontracted to the Pharmacy Benefit Manager (PBM) for the specific purpose of providing pharmacy services to Members.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Pharmacy Home Program	A program by which a Member selects or is assigned to single provider of pharmaceutical services.
Polypharmacy	The simultaneous use of multiple medications by a single Member, for one (1) or more conditions.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.

For 20191205BOD Review

Policy: GG.1423
Title: **Medication Quality Assurance Program**
Department: Medical Affairs
Section: Pharmacy Management

CEO Approval: Michael Schrader _____

Effective Date: 06/07/2011
Revised Date: TBD

For 20191205BOD Review

I. PURPOSE

This policy establishes a quality assurance program to reduce medication errors and adverse drug interactions, and improve medication use through prospective and retrospective drug utilization review (DUR).

II. POLICY

A. CalOptima shall ensure that **Participating Pharmacies*** comply with the minimum standards for pharmacy practice as established by California in accordance with the California Business and Professions Code, Section 4000 *et. seq*.

B. CalOptima or its **Pharmacy Benefit Manager (PBM)** shall maintain quality assurance measures and systems including:

1. Prospective drug utilization review (DUR) systems;

2. Retrospective drug utilization review (DUR) systems; and

3. Internal medication error identification and reduction systems.

C. CalOptima shall provide information to the Department of Health Care Services (DHCS) regarding its quality assurance measures and systems pertaining to improving medication use, reducing medication errors, and adverse drug interactions.

D. CalOptima shall provide Members access to view their drug profile and to perform drug formulary validation in accordance with CalOptima Policy GG.1424: Pharmacy Benefit Information for Members.

E. CalOptima shall perform medication reconciliation in accordance with CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply.

F. CalOptima shall establish systems and measures to ensure that **Participating Pharmacies** comply with CalOptima's quality assurance requirements.

G. The **PBM** shall ensure that **Participating Pharmacies** offer patient counseling to Members, when appropriate, in accordance with state law.

H. Electronic Prescription Drug Program .

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

1. The **PBM** shall support electronic prescribing in accordance with applicable federal and state laws, regulations and standards, including, without limitations, Subpart D of 42 CFR Part 423.

2. The **PBM** shall establish and maintain an electronic prescription drug program that complies with applicable standards, including, without limitations, 42 CFR § 423.160(b), when transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media for Members.

3. The **PBM** shall ensure that all necessary contracts and systems are in place should prescribing health care practitioners desire to electronically transmit prescriptions for Members. The PBM shall ensure that **Participating Pharmacies**:

    a. Can receive electronic prescriptions (with allowance for exceptions when it is impractical or otherwise could jeopardize beneficiary access) in accordance with applicable standards. The **PBM** shall have an approval process for such exceptions and a process to redirect prescribing health care practitioners to appropriate alternate **Participating Pharmacies**.

    b. Process electronic prescriptions received from prescribing health care practitioners, when appropriate, in accordance with all applicable federal and state laws, regulations, and standards.

    c. Immediately notify the prescribing health care practitioner when the **Participating Pharmacy**, or its staff, is aware that an attempted transmission of an electronic prescription failed, is incomplete, or otherwise not properly received.

I. **Participating Pharmacies** shall implement a method to keep Member information records and maintain up-to-date Member information including, but not limited to:

1. Member demographic information; and

2. Member allergy information including drug and food allergies.

J. CalOptima shall make efforts toward including the following in quality assurance systems:

1. Electronic prescribing;

2. Clinical decision support systems;

3. Educational interventions;

4. Adverse event reporting systems; and

5. Provider and Member education.

K. Effective July 1, 2017, CalOptima shall participate in a global Medi-Cal DUR program. The global Medi-Cal DUR program will assess data on drug use against predetermined standards, consistent with the following:

1. Compendia, which shall consist of the following:

    a. American Hospital Formulary Service Drug Information;

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b. United States Pharmacopeia-Drug Information (or its successor publications);

c. The DrugDex Information System; and

2. Peer-reviewed medical literature.

L. CalOptima shall include the participation with the Medi-Cal DUR Board as part of its DUR Program activities.

1. CalOptima shall actively participate directly in the Medi-Cal DUR Board by means of the California Association of Health Plans.

2. On a quarterly basis, CalOptima shall assess the Medi-Cal DUR Board's recommendations and decide if it will adopt their recommendations or not. If CalOptima chooses not to adopt certain recommendations, a justification shall be provided to DHCS as part of the annual DUR report outlined in Section II.N of this policy.

M. CalOptima shall provide educational efforts and outreach programs, in collaboration with the Medi-Cal DUR Board, to improve the ability of physicians and pharmacists to identify patterns, and reduce the frequency, of fraud, abuse, misuse, and clinically inappropriate or medically unnecessary care. In addition to these educational outreach programs, CalOptima shall also distribute additional educational materials or articles based on the demographics and trends specific to Member and Provider populations.

N. CalOptima shall submit a detail DUR report to DHCS, in a format specified by DHCS, on its DUR Program activities by April 1 of each year. The report shall include information related to the methodology by which CalOptima meets the requirements for the prospective and retrospective DUR. In addition, CalOptima shall also provide in its annual DUR report any educational programs provided outside of the global educational activities, the rationale for not implementing DUR Board recommended actions, and any other DUR related activities performed outside of the global DUR activities, as applicable.

III. PROCEDURE

A. A **Participating Pharmacy** shall conduct prospective DUR to ensure review of the prescribed drug therapy prior to dispensing or delivering a prescription to a Member. The prospective drug utilization review shall include, but not be limited to:

1. Screening for potential drug therapy problems due to therapeutic duplication;

2. Ingredient duplication;

3. Age and gender-related drug utilization;

4. Drug-to-drug interactions, including serious interactions with non-prescription or over-the-counter drugs;

5. Incorrect drug dosage, such as low or high dose, or duration of drug therapy;

6. Drug-disease contraindications;

7. Drug pregnancy precautions;

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8. Drug-allergy contraindications; and

9. Clinical abuse or misuse.

B. CalOptima shall conduct retrospective DUR on a monthly basis to ensure ongoing examination of claims data and other records through computerized drug claims processing and information retrieval systems to:

1. Identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among **Prescribing Providers, Participating Pharmacies**, and Members; and

2. Identify fraud and abuse patterns associated with specific drugs or groups of drugs.

C. The Pharmacy Management Department shall conduct retrospective DUR using the following methods which include, but are not limited to:

1. Claims oversight for the following:

a. Claims for Medi-Cal FFS carve out medications;

b. Claims for Medicare Part D-covered drugs for dual-eligible members;

c. Over the counter drugs processed for members in Long-Term-Care Facilities;

d. Acetaminophen products for adults over twenty-one (21) years of age;

e. Over the counter cough and cold products for adults over twenty-one (21) years of age;

f. Claims payment for members who are deceased;

g. Members with paid claims from out of state pharmacies;

h. Claims with member copayments;

i. Compounding claims with incorrect level of effort codes;

j. Claims with incorrect dispensing fees; and

k. Claims with incorrect quantities.

2. Members with potential over-utilization of pharmaceuticals as identified through:

a. The **Polypharmacy** Management Program;

b. The **Pharmacy Home Program**; and

c. The Prescriber Restriction Program.

3. Identify Members with potential over-utilization of controlled substances.

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4. Members with potential under-utilization of pharmaceuticals as identified through the following reports:

   a. Members with diabetes and not receiving a statin;

   b. Members with cardiovascular disease not receiving a statin; and

   c. Members hospitalized for an acute myocardial infarction not receiving persistent beta-blocker treatment for six (6) months after discharge.

5. For Members identified with over- or under-utilization of pharmaceuticals, CalOptima Pharmacy Management Department shall outreach to the Member's Primary Care Physician (PCP) with recommendations to either remove or add additional therapy to the Member's drug regimen. The result of this outreach shall be tracked and reported quarterly at the Pharmacy and Therapeutics (P&T) Committee Meetings.

6. Other programs relating to the **Health Effectiveness Data and Information Set (HEDIS)**.

D. The Pharmacy Management Department shall refer all potential drug-related Quality of Care issues to the Quality Improvement Department for follow-up.

E. CalOptima shall utilize the Food and Drug Administration (FDA) Medwatch form for reporting adverse events and shall educate Providers about the availability of the Medwatch form.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1408: Pharmacy Audits and Reviews
C. CalOptima Policy GG.1413: Polypharmacy Management
D. CalOptima Policy GG.1416: Pharmacy Home Program
E. CalOptima Policy GG.1611: Potential Quality Issue Review Process
F. CalOptima Policy GG.1424: Pharmacy Benefit Information for Members.
G. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-008: Requirement to Participate in the Medi-Cal Drug Utilization Review Program
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements
J. Health Homes Program Guide
K. Business and Professions Code, §§ 688 and 4070-4072
L. Health and Safety Code §§ 11164-11164.5
M. Title 16, California Code of Regulations (C.C.R.), § 1717.4
N. Title 21, Code of Federal Regulations (C.F.R.), § 1311.200
O. Title 42, Code of Federal Regulations (C.F.R.), Part 456, Subpart K
P. Title 42, Code of Federal Regulations (C.F.R.), §§ 423.159, 423.160, and 438.3(s)(4)-(5)
Q. Section 1927(g) of the Social Security Act (SSA)

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/12/17: Department of Health Care Services

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B. 08/09/16: Department of Health Care Services
C. 08/21/14: Department of Health Care Services

VII. BOARD ACTION(S)

A. 09/05/2019: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/07/2011	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	01/01/2012	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	05/01/2014	GG.1423	Medication Quality Assurance Program	Medi-Cal
Reviewed	10/01/2015	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	06/01/2016	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	07/01/2017	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	01/01/2018	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	TBD	GG.1423	Medication Quality Assurance Program	Medi-Cal

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IX. GLOSSARY

Term	Definition
Healthcare Effectiveness Data and Information Set (HEDIS™):	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Participating Pharmacy	Any pharmacy that is credentialed by and subcontracted to the Pharmacy Benefit Manager (PBM) for the specific purpose of providing pharmacy services to Members.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Pharmacy Home Program	A program by which a Member selects or is assigned to single provider of pharmaceutical services.
Polypharmacy	The simultaneous use of multiple medications by a single Member, for one (1) or more conditions.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of Modifications of CalOptima Policies and Procedures Related to CalOptima's Whole-Child Model (WCM) Program

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

Approve modifications to the following Policies and Procedures in connection with Whole-Child Model program as follows:

1. DD.2006: Enrollment In/ Eligibility with CalOptima [Medi-Cal]
2. DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process [Medi-Cal]
3. GG.1125: Cancer Clinical Trials [Medi-Cal, OneCare, OneCare Connect]
4. GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices [Medi-Cal]

Background

The California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children under age 21 who meet eligibility criteria based on financial and medical conditions. Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal Managed Care Plan (MCP) contracts for County Organized Health Systems (COHS) on a phased-in basis.

On November 9, 2018, DHCS delayed the implementation of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS determined that more time is needed to ensure effective preparation and a robust number of CCS-paneled providers. On November 21, 2018 and December 18, 2018, DHCS provided updated WCM provider network adequacy standards that all CalOptima health networks must meet in order to participate in the WCM. Additionally, on December 23, 2018, DHCS released All Plan Letter (APL) 18-023 California Children's Services Whole-Child Model, which superseded the APL originally published on June 7, 2018, and included clarifying language and new guidance regarding Neonatal Intensive Care Unit (NICU), High Risk Infant Follow-up (HRIF) program, pediatric palliative care, and continuity of care appeals.

On December 6, 2018, the CalOptima Board of Directors authorized modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program to no sooner than July 1, 2019. Additional policies and procedure require

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modification due to the delayed WCM implementation date, provider network adequacy standards and regulatory guidance.

Discussion

DHCS released updated network adequacy standards for 27 identified provider types and specialties on November 21, 2018, which was further updated on December 18, 2018. CalOptima's health networks are required to contract with 23 of the 27 identified provider types and CalOptima is responsible for contracting with the remaining four on behalf of the entire network. The remaining four specialty types are considered rare specialties and include, Pediatric Dermatology, Pediatric Developmental and Behavioral Medicine, Oral and Maxillofacial Surgery and Transplant Hepatology. Health networks must meet the adequacy standards as certified by DHCS to participate in WCM. Members may only receive CCS services through a participating health network.

All health networks are expected to meet applicable network adequacy requirements; final evidence of network adequacy was submitted to DHCS on March 1, 2019. Network adequacy will be evaluated, at a minimum, on an annual basis. While not expected, CalOptima has modified its policy and procedures to ensure that members eligible for CCS are not assigned to a health network not participating in WCM. Additionally, processes were established to notify members assigned to a health network that is later determined to not meet WCM provider network adequacy standards.

Below is additional information regarding the modified policies which include revisions related to WCM as well as clarification related to existing operations:

1. ***DD.2006: Enrollment In/ Eligibility with CalOptima*** defines the criteria by which CalOptima enrolls a member in CalOptima Direct. CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory requirements including the WCM program. Revisions include modifications to the process for members undergoing a transplant to transition from a health network to CalOptima Community Network (CCN). With respect to WCM, the revisions clarify that transitioning members with select chronic conditions from delegated health networks to CalOptima Community Network will be effective on and after the WCM implementation date.

2. ***DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process*** describes the process in which a health network eligible member shall select CalOptima Community Network (CCN) or a health network, and CCN or the health network's responsibilities for such member. CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory requirements including the WCM program. With respect to WCM, the revisions address requirements that a member may only receive services through a WCM participating network that has met DHCS network adequacy requirements.

3. ***GG.1125: Cancer Clinical Trials*** outlines coverage guidelines for routine health care services provided in connection with a member's participation in a cancer clinical trial. CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory

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requirements including the WCM program. With respect to WCM, the revisions address CalOptima's expanded responsibility for Cancer Clinical Trials for CCS members under WCM.

4. ***GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices*** outlines the durable medical equipment (DME) guidelines and medical necessity criteria for reimbursement of medically necessary automobile orthopedic positioning devices (AOPD). CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory requirements including the WCM program. With respect to WCM, the revisions address CalOptima's expanded responsibility for AOPD for CCS members under WCM.

Additional policies are expected to be submitted for Board approval at a later time.

Fiscal Impact
The recommended action to modify existing policies and procedures, DD.2006, DD.2008, GG.1125 and GG.1515 in connection with the WCM program is not expected to have an additional fiscal impact beyond CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks, approved by the Board on October 4, 2018. Management will include all projected revenues and expenses associated with the WCM program in the Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation
To ensure CalOptima meets all requirements of the Whole-Child Model program, approval of the requested actions is recommended.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. DD.2006: Enrollment In/ Eligibility with CalOptima (redline and clean versions)
2. DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process (redline and clean versions)
3. GG.1125: Cancer Clinical Trials (redline and clean versions)
4. GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices (redline and clean versions)
5. Board Action December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date
6. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program
7. DHCS All Plan Letter 18-011 California Children's Services Whole-Child Model Program

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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Policy #: DD.2006
Title: **Enrollment In/Eligibility with CalOptima Direct**
Department: Customer Service
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 10/01/1995
Revision Date: 04/04/2019

I. PURPOSE

This policy defines the criteria by which CalOptima enrolls a **Member** in **CalOptima Direct**.

II. POLICY

A. CalOptima may enroll a **Member** in **CalOptima Direct**, in accordance with this Policy.

B. CalOptima shall enroll the following **Members** in **CalOptima Direct Administrative (COD-A)** subject to the provisions of this Policy:

1. A **Member** who has Medicare coverage and is not enrolled in OneCare or OneCare Connect~~:~~.

~~1. For a Member who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in CalOptima Direct pursuant to this policy, CalOptima shall not be required to assign such Members who are eligible for services through Medicare to a Medi-Cal Primary Care Provider (PCP) or require them to select a Medi-Cal PCP in accordance with the policy of the Department of Health Care Services (DHCS).~~
A **member**
~~2. For a Member who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in CalOptima Direct, pursuant to this policy, CalOptima shall assign such Member to a Medi-Cal PCP in accordance with DHCS policy(s).~~

2. ~~A Member~~ who becomes the responsibility of the Public Guardian or is in an Institute for Mental Disease (IMD), or with Orange County Children and Family Services and ~~is~~ placed outside of Orange County.

3. A **Member** with a **Share of Cost (SOC) Aid Code**.

4. A **Member** who resides at the Fairview Developmental Center.

5. At the time of initial enrollment in CalOptima, a **Member** with a non-Orange County zZip cCode, or invalid address information from the State.

a. If the address and/or zip code changes to an Orange County address at a later date, CalOptima shall request that the **Member** select a **Health Network** or **CalOptima Community Network (CCN)**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

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

C. CalOptima shall enroll a **Member** in **CCN in the following circumstances**, unless eligible for enrollment in **COD-A** ~~as described above, subject to the following provisions of this Policy:~~under Section II.B.:

1. A **Member** with Long Term Care (LTC) **Aid Code**;

2. A **Member** with a Breast and Cervical Cancer Treatment Program (BCCTP) primary **Aid Code**;

3. A **Health Network Eligible Member**, except as otherwise identified in this Policy~~:~~, who is at least twenty-one (21) years old. The age provision shall no longer apply on and after the implementation date of the Department of Health Care Services (DHCS) approved Whole-Child Model (WCM) program, and:

   a. Is diagnosed with hemophilia;

   b. Is listed for a **Solid Organ Transplant** or approved for a Bone Marrow Transplant (BMT). ~~identified by a Provider as a potential candidate for a Solid Organ Transplant at a DHCS-approved Transplant Center or a **California Children's Services (CCS)** paneled Transplant Special Care Center, and the Provider has requested authorization for Covered Services, or is approved for a Bone Marrow Transplant (BMT), except if the Member is listed as **Status 7**;~~

   c. Has received a **Solid Organ Transplant** or BMT within one hundred twenty (120) calendar days prior to the **Member's** effective date of enrollment in CalOptima; or

   d. Is diagnosed with **End Stage Renal Disease (ESRD)**.

~~Notwithstanding Section II.C.3., **members** under the age of twenty-one (21) years shall not be assigned to CCN. This provision shall no longer apply on and after the implementation date of the Department of Health Care Services (DHCS) approved Whole-Child Model (WCM) program.~~

D. If a **Member** is no longer required to be enrolled in **COD-A** or **CCN** as described in Sections II.B or II.C, such **Member**:

1. Is a **Health Network Eligible Member**;

2. May select **CalOptima Community Network** or any other **Health Network** in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

E. CalOptima shall exclude a **Health Network Eligible Member** from the provisions of this P~~p~~olicy if such **Member** is enrolled in a **Health Maintenance Organization (HMO)** that, pursuant to the **Health Network's** Contract, is responsible for all **Covered Services** for the **Member**.

F. **COD-A** is responsible for a **Health Network Eligible Member** until such **Member** selects a **Health Network** or is assigned to a **Health Network**, pursuant to CalOptima Policies DD.2008:

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Health Network and CalOptima Community Network Selection Process or AA.1207a: CalOptima Auto-Assignment~~.~~, respectively.

G. **CalOptima Direct** is not responsible for **Covered Services** provided to a **Member** outside the United States, with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22, California Code of Regulations, Section 51006.

III. PROCEDURE

A. At the time of initial enrollment in CalOptima, a **Member** with a zip code outside of Orange County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to verify a zip code within Orange County due to no address information provided by the State, such **Member** shall not be auto-assigned by CalOptima, and the **Member** shall remain in **COD-A**.

B. If a **Member** assigned to **COD-A** due to having a zip code outside Orange County changes his or her zip code to an Orange County zip code, CalOptima shall request that the **Member** select a **Health Network** or **CCN**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto-assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

~~B.~~

C. If a current **Member** assigned to a **Health Network** has or receives a zip code outside of Orange County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to verify a zip code within Orange County at a later date, the **Member** may remain with their assigned **Health Network** unless **Member** makes a different **Health Network** choice or meets the criteria for **COD-A** or **CCN** enrollment as stated in Section II.B or II.C.

D. If a **Health Network Eligible Member** becomes the responsibility of the Public Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and Family Services and resides outside Orange County:

1. The ~~**Member's Public**~~**Member's** Public Guardian, or the Orange County Children and Family Services may submit a written request to enroll the **Member** in **COD-A**.

   a. If CalOptima receives such request to enroll the **Member** in **COD-A** by the tenth (10th) calendar day of the month, **CalOptima Direct** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1st) calendar day of the immediately following month.

   b. If CalOptima receives such request after the tenth (10th) calendar day of the month, **COD-A** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month.

2. If the **Member's** Public Guardian, ~~or Orange~~or Orange County Children and Family Services does not submit a written request to enroll the **Member** in **CalOptima Direct**, the **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **Division of Financial Responsibility (DOFR)**.

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3. If the **Member** returns to Orange County, the Public Guardian or Orange County Children and Family Services may submit a written request to enroll the **Member** in a **Health Network** or **CCN**.

E. If a **Health Network Eligible Member** is diagnosed with Hemophilia:

1. The **Member's Health Network** shall notify CalOptima of the **Member's** diagnosis, in writing, using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members.

   a. If the **Health Network** notifies CalOptima, in writing, by the tenth (10th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1st) calendar day of the ~~immediate~~immediately following month.

   b. If the **Health Network** notifies CalOptima, in writing, after the tenth (10th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, to enroll the **Member** in **CalOptima Direct**, and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.~~D~~E.1 of this Policy.

F. If a **Health Network Eligible Member**, is listed for a **Solid Organ Transplant** or approved for a BMT.~~identified by a Provider as a potential candidate for a Solid Organ Transplant at a DHCS-approved Transplant Center or a **CCS** paneled Transplant Special Care Center, and the Provider has requested authorization for Covered Services, or the Member is approved for Bone Marrow Transplant (BMT) at a DHCS-approved Transplant Center or **CCS** paneled Transplant Special Care Center, and is not listed as **Status 7:**~~

1. The **Member's Health Network** shall notify CalOptima, in writing, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

   a. Except as set forth in Section III.~~D~~F.1.b of this P~~p~~olicy, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**.

   b. If the **Member** receives a **Solid Organ Transplant** or BMT after the date the **Health Network** notifies CalOptima and before the first (1st) calendar day of the month immediately following the date CalOptima receives notice, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month of notice.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, and CalOptima transitions such **Member** to **CalOptima Direct** as set forth in Section III.~~D~~F.1. of this P~~p~~olicy.

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3. **CCN** shall be responsible for all **Covered Services** for the **Member** for three- hundred sixty-five (365) calendar days after the **Member** receives a **Solid Organ Transplant** or BMT. After three-hundred sixty-five (365) calendar days after the date the **Member** receives a **Solid Organ Transplant** or BMT, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

4. If CalOptima, the DHCS-approved Transplant Center, or the **CCS**-paneled Transplant Special Care Center, determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT:

   a. If it has been less than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective the first (1st) calendar day of the month immediately following the date CalOptima or the DHCS-approved Transplant Center determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT; or

   b. If it has been more than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network Selection Process, or CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

G. If a **Health Network Eligible Member**, except a Kaiser **Member**, is identified as a potential candidate for ~~received~~ a **Solid Organ Transplant** or a BMT: ~~within one hundred twenty (120) calendar days prior to their effective date of enrollment in CalOptima:~~

1. The **Member's Health Network** shall notify CalOptima by sending a Notification of Transplant Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

2. **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**, for a period of not less than three hundred sixty-five (365) calendar days after the date the **Member** received such Transplant.

3. CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective no later than the first (1st) calendar day of the month immediately following the three hundred sixty fifth (365th) calendar day after the date the **Member** received a **Solid Organ Transplant** or BMT.

4. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member** until the **Health Network** submits written notice and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.~~E~~G.1 and III.~~E~~G.2 of this Policy.

H. If a **Health Network Eligible Member** is diagnosed with **ESRD** and is not already assigned to **CCN**:

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1. The **Member's Health Network** shall notify CalOptima, in writing, of the **Member** by submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network Relations Department.

    a. If a **Health Network** submits a Form CMS-2728-U3 on or before the fifteenth (15th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the ~~immediate~~immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 15, **CCN** shall assume responsibility for the **Member** effective August 1.

    b. If a **Health Network** submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the second (2nd) month after the immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 16, **CCN** shall assume responsibility for the **Member** effective September 1.

    c. CalOptima shall provide the **Member** with a thirty (30) calendar day notice of the transition, pursuant to the CalOptima Contract with DHCS.

I. If CalOptima identifies a **Member** who meets the requirements specified in Sections II.B and II.C, of this P~~p~~olicy, CalOptima shall transition the **Member** to **COD-A**, or **CCN**, and notify the **Member's Health Network** of such transition. CalOptima shall provide the **Member**, with a thirty (30) calendar day notice of the transition pursuant to CalOptima's contract with DHCS.

1. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until CalOptima enrolls the **Member** in **COD-A** or **CCN**.

J. If CalOptima identifies a **Member** who meets the requirements specified in Section II.B.1.~~b~~ of this P~~p~~olicy, CalOptima shall assign the **Member** a **PCP** as follows:

1. For a **member** who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in **CalOptima Direct** pursuant to this P~~p~~olicy, CalOptima shall not be required to assign such **members** who are eligible for services through Medicare to a Medi-Cal **Primary Care Provider (PCP)** or require them to select a Medi-Cal **PCP** in accordance with the policy of the Department of Health Care Services (DHCS).

2. For a **member** who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in **CalOptima Direct**, pursuant to this P~~p~~olicy, CalOptima shall assign such **member** to a Medi-Cal **PCP** in accordance with DHCS policy(s).

3. For an existing **Member** assigned to a **Health Network**, who gains Part A-only Dual status, CalOptima shall transition the **Member** to **COD-A** in the month CalOptima is notified by the State of the change to Medicare Part A eligibility.

    a. CalOptima shall assign the **Member** a **PCP** in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

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4. For a newly enrolled **Member** who is also Medicare Part A-only Dual eligible, CalOptima shall assign the **Member** to a **PCP** in accordance with the methodology described in CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

5. A **Member** may request to change his or her participating **PCP** every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

IV. ATTACHMENT(S)

A. Notification of Transplant Member
B. Hemophilia Special Needs Screen Questionnaire
C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy FF.1001: Capitation Payment
H. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
~~H.~~I. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
~~I.~~J. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
~~J.~~K. California Health and Safety Code, §§ 104160 through 104163
~~K.~~L. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in Medi-Cal Managed Care for Dual-Eligible Beneficiaries
~~L.~~M. Department of Health Care Services All Plan Letter (APL) 18-~~011~~023: California Children's Services Whole Child Model Program
~~M.~~N. Title 22, California Code of Regulations, §51006
~~N.~~O. Welfare and Institutions Code, §14182.17(d)(3)

VI. REGULATORY AGENCY APPROVAL(S)

A. 10/07/15: Department of Health Care Services
B. 08/18/15: Department of Health Care Services
C. 04/01/15: Department of Health Care Services
D. 10/01/12: Department of Health Care Services

VII. BOARD ACTION(S)

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 09/06/18: Regular Meeting of the CalOptima Board of Directors

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~~B.~~C. 08/06/15: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 03/06/14: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 03/04/10: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 11/05/09: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 06/03/08: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 10/19/06: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~#	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	10/01/1995	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	02/01/1996	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	03/01/1997	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2006	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2007	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2008	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2010	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	01/01/2011	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	10/01/2012	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	03/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	05/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Reviewed	02/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	07/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/06/2018	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	04/04/2019	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

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~~X.~~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~~member is eligible to receive Medi-Cal ~~Covered Services~~covered services.
California Children's Services Program	~~For the purposes of this policy, the~~The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~persons~~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 (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (***PCP***) to manage the care of the ~~Member~~member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to ~~Members~~members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A ~~Member~~member who receives all ~~Covered Services~~covered services through CalOptima Direct.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
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~~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~~members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division ~~of~~Of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of ~~Covered Services.~~covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

Term	Definition
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide ~~Covered Services~~covered services to ~~Members~~members assigned to that ~~Health Network~~health network.
Health Network Eligible Member	A ~~Member~~member who is eligible to choose a CalOptima ~~Health Network~~health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to ~~Members~~members and serves as the medical home for ~~Members~~members.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; and 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

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Policy #:	DD.2006
Title:	**Enrollment In/Eligibility with CalOptima Direct**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	10/01/1995
Revision Date:	04/04/2019

I. PURPOSE

This policy defines the criteria by which CalOptima enrolls a **Member** in **CalOptima Direct**.

II. POLICY

A. CalOptima may enroll a **Member** in **CalOptima Direct**, in accordance with this Policy.

B. CalOptima shall enroll the following **Members** in **CalOptima Direct Administrative (COD-A)** subject to the provisions of this Policy:

1. A **Member** who has Medicare coverage and is not enrolled in OneCare or OneCare Connect.

2. A **member** who becomes the responsibility of the Public Guardian or is in an Institute for Mental Disease (IMD), or with Orange County Children and Family Services and placed outside of Orange County.

3. A **Member** with a **Share of Cost (SOC) Aid Code**.

4. A **Member** who resides at the Fairview Developmental Center.

5. At the time of initial enrollment in CalOptima, a **Member** with a non-Orange County zip code, or invalid address information from the State.

    a. If the address and/or zip code changes to an Orange County address at a later date, CalOptima shall request that the **Member** select a **Health Network** or **CalOptima Community Network (CCN)**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. CalOptima shall enroll a **Member** in **CCN in the following circumstances**, unless eligible for enrollment in **COD-A** under Section II.B.:

1. A **Member** with Long Term Care (LTC) **Aid Code**;

2. A **Member** with a Breast and Cervical Cancer Treatment Program (BCCTP) primary **Aid Code**;

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

3. A **Health Network Eligible Member**, except as otherwise identified in this Policy, who is at least twenty-one (21) years old. The age provision shall no longer apply on and after the implementation date of the Department of Health Care Services (DHCS) approved Whole-Child Model (WCM) program, and:

    a. Is diagnosed with hemophilia;

    b. Is listed for a **Solid Organ Transplant** or approved for a Bone Marrow Transplant (BMT).

    c. Has received a **Solid Organ Transplant** or BMT within one hundred twenty (120) calendar days prior to the **Member's** effective date of enrollment in CalOptima; or

    d. Is diagnosed with **End Stage Renal Disease (ESRD)**.

D. If a **Member** is no longer required to be enrolled in **COD-A** or **CCN** as described in Sections II.B or II.C, such **Member**:

1. Is a **Health Network Eligible Member**;

2. May select **CalOptima Community Network** or any other **Health Network** in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

E. CalOptima shall exclude a **Health Network Eligible Member** from the provisions of this Policy if such **Member** is enrolled in a **Health Maintenance Organization (HMO)** that, pursuant to the **Health Network's** Contract, is responsible for all **Covered Services** for the **Member**.

F. **COD-A** is responsible for a **Health Network Eligible Member** until such **Member** selects a **Health Network** or is assigned to a **Health Network**, pursuant to CalOptima Policies DD.2008: Health Network and CalOptima Community Network Selection Process or AA.1207a: CalOptima Auto-Assignment, respectively.

G. **CalOptima Direct** is not responsible for **Covered Services** provided to a **Member** outside the United States, with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22, California Code of Regulations, Section 51006.

III. PROCEDURE

A. At the time of initial enrollment in CalOptima, a **Member** with a zip code outside of Orange County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to verify a zip code within Orange County due to no address information provided by the State, such **Member** shall not be auto-assigned by CalOptima, and the **Member** shall remain in **COD-A**.

B. If a **Member** assigned to **COD-A** due to having a zip code outside Orange County changes his or her zip code to an Orange County zip code, CalOptima shall request that the **Member** select a **Health Network** or **CCN**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto-assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. If a current **Member** assigned to a **Health Network** has or receives a zip code outside of Orange County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to

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verify a zip code within Orange County at a later date, the **Member** may remain with their assigned **Health Network** unless **Member** makes a different **Health Network** choice or meets the criteria for **COD-A** or **CCN** enrollment as stated in Section II.B or II.C.

D. If a **Health Network Eligible Member** becomes the responsibility of the Public Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and Family Services and resides outside Orange County:

1. The **Member's** Public Guardian, or the Orange County Children and Family Services may submit a written request to enroll the **Member** in **COD-A**.

   a. If CalOptima receives such request to enroll the **Member** in **COD-A** by the tenth (10th) calendar day of the month, **CalOptima Direct** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1st) calendar day of the immediately following month.

   b. If CalOptima receives such request after the tenth (10th) calendar day of the month, **COD-A** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month.

2. If the **Member's** Public Guardian, or Orange County Children and Family Services does not submit a written request to enroll the **Member** in **CalOptima Direct**, the **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **Division of Financial Responsibility (DOFR)**.

3. If the **Member** returns to Orange County, the Public Guardian or Orange County Children and Family Services may submit a written request to enroll the **Member** in a **Health Network** or **CCN**.

E. If a **Health Network Eligible Member** is diagnosed with Hemophilia:

1. The **Member's Health Network** shall notify CalOptima of the **Member's** diagnosis, in writing, using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members.

   a. If the **Health Network** notifies CalOptima, in writing, by the tenth (10th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1st) calendar day of the immediately following month.

   b. If the **Health Network** notifies CalOptima, in writing, after the tenth (10th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, to enroll the **Member** in **CalOptima Direct**, and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.E.1 of this Policy.

F. If a **Health Network Eligible Member**, is listed for a **Solid Organ Transplant** or approved for a BMT.

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1. The **Member's Health Network** shall notify CalOptima, in writing, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

    a. Except as set forth in Section III.F.1.b of this Policy, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**.

    b. If the **Member** receives a **Solid Organ Transplant** or BMT after the date the **Health Network** notifies CalOptima and before the first (1st) calendar day of the month immediately following the date CalOptima receives notice, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month of notice.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, and CalOptima transitions such **Member** to **CalOptima Direct** as set forth in Section III.F.1. of this Policy.

3. **CCN** shall be responsible for all **Covered Services** for the **Member** for three- hundred sixty-five (365) calendar days after the **Member** receives a **Solid Organ Transplant** or BMT. After three-hundred sixty-five (365) calendar days after the date the **Member** receives a **Solid Organ Transplant** or BMT, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

4. If CalOptima, the DHCS-approved Transplant Center, or the **CCS-**paneled Transplant Special Care Center, determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT:

    a. If it has been less than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective the first (1st) calendar day of the month immediately following the date CalOptima or the DHCS-approved Transplant Center determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT; or

    b. If it has been more than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network Selection Process, or CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

G. If a **Health Network Eligible Member**, except a Kaiser **Member**, is identified as a potential candidate for a **Solid Organ Transplant** or a BMT:

1. The **Member's Health Network** shall notify CalOptima by sending a Notification of Transplant Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

2. **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**, for a period of not less than three hundred sixty-five (365) calendar days after the date the **Member** received such Transplant.

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3. CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective no later than the first (1st) calendar day of the month immediately following the three hundred sixty fifth (365th) calendar day after the date the **Member** received a **Solid Organ Transplant** or BMT.

4. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member** until the **Health Network** submits written notice and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.G.1 and III.G.2 of this Policy.

H. If a **Health Network Eligible Member** is diagnosed with **ESRD** and is not already assigned to **CCN**:

1. The **Member's Health Network** shall notify CalOptima, in writing, of the **Member** by submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network Relations Department.

a. If a **Health Network** submits a Form CMS-2728-U3 on or before the fifteenth (15th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 15, **CCN** shall assume responsibility for the **Member** effective August 1.

b. If a **Health Network** submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the second (2nd) month after the immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 16, **CCN** shall assume responsibility for the **Member** effective September 1.

c. CalOptima shall provide the **Member** with a thirty (30) calendar day notice of the transition, pursuant to the CalOptima Contract with DHCS.

I. If CalOptima identifies a **Member** who meets the requirements specified in Sections II.B and II.C, of this Policy, CalOptima shall transition the **Member** to **COD-A**, or **CCN**, and notify the **Member's Health Network** of such transition. CalOptima shall provide the **Member**, with a thirty (30) calendar day notice of the transition pursuant to CalOptima's contract with DHCS.

1. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until CalOptima enrolls the **Member** in **COD-A** or **CCN**.

J. If CalOptima identifies a **Member** who meets the requirements specified in Section II.B.1. of this Policy, CalOptima shall assign the **Member** a **PCP** as follows:

1. For a **member** who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in **CalOptima Direct** pursuant to this Policy, CalOptima shall not be required to assign such **members** who are eligible for services through Medicare to a Medi-Cal **Primary Care Provider (PCP)** or require them to select a Medi-Cal **PCP** in accordance with the policy of the Department of Health Care Services (DHCS).

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2. For a **member** who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in **CalOptima Direct**, pursuant to this Policy, CalOptima shall assign such **member** to a Medi-Cal **PCP** in accordance with DHCS policy(s).

3. For an existing **Member** assigned to a **Health Network**, who gains Part A-only Dual status, CalOptima shall transition the **Member** to **COD-A** in the month CalOptima is notified by the State of the change to Medicare Part A eligibility.

    a. CalOptima shall assign the **Member** a **PCP** in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

4. For a newly enrolled **Member** who is also Medicare Part A-only Dual eligible, CalOptima shall assign the **Member** to a **PCP** in accordance with the methodology described in CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

5. A **Member** may request to change his or her participating **PCP** every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

IV. ATTACHMENT(S)

A. Notification of Transplant Member
B. Hemophilia Special Needs Screen Questionnaire
C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy FF.1001: Capitation Payment
H. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
I. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
J. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
K. California Health and Safety Code, §§ 104160 through 104163
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in Medi-Cal Managed Care for Dual-Eligible Beneficiaries
M. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program
N. Title 22, California Code of Regulations, §51006
O. Welfare and Institutions Code, §14182.17(d)(3)

VI. REGULATORY AGENCY APPROVAL(S)

A. 10/07/15: Department of Health Care Services
B. 08/18/15: Department of Health Care Services

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C. 04/01/15: Department of Health Care Services
D. 10/01/12: Department of Health Care Services

VII. BOARD ACTION(S)

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
B. 09/06/18: Regular Meeting of the CalOptima Board of Directors
C. 08/06/15: Regular Meeting of the CalOptima Board of Directors
D. 03/06/14: Regular Meeting of the CalOptima Board of Directors
E. 03/04/10: Regular Meeting of the CalOptima Board of Directors
F. 11/05/09: Regular Meeting of the CalOptima Board of Directors
G. 06/03/08: Regular Meeting of the CalOptima Board of Directors
H. 10/19/06: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	10/01/1995	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	02/01/1996	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	03/01/1997	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2006	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2007	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2008	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2010	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	01/01/2011	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	10/01/2012	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	03/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	05/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Reviewed	02/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	07/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/06/2018	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	04/04/2019	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

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IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a member is eligible to receive Medi-Cal covered services.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
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 (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (***PCP***) to manage the care of the member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A member who receives all covered services through CalOptima Direct.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
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 defines how CalOptima identifies the responsible parties for components of medical associated with the provision of covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

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Term	Definition
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to members assigned to that health network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; and 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

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P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

ADULT TRANSPLANT NOTIFICATION AND REQUEST FORM

Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607

PHASE: ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

***** 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: _____ (Last / First) ☐ M ☐ F D.O.B. _____ Age: _____

Mailing Address: _____ City: _____ ZIP: _____ Phone: _____

Client Index # (CIN): _____

Referring Provider:

Provider NPI#: _____ TIN#: _____

Medi-Cal ID#: _____

Address: Phone: _____

Fax: _____

Office Contact: _____

Physician's Signature: _____

Diagnosis: _____ ICD-9: _____

TRANSPLANT TYPE
(CalOptima may redirect based on contract status or center availability)

BMT:	☐ Cedars	
DLI:	☐ Cedars	
Kidney:	☐ UCI	
Kidney Pancreas:	☐ California Pacific	☐ UCSF
Liver:	☐ Cedars	☐ USC
Liver and Kidney:	☐ Cedars	☐ USC
Lung:	☐ USC	
Heart:	☐ Cedars	☐ USC
Heart and Lung:	☐ Stanford	
Small Bowel:	☐ Cedars	☐ USC

☐ Inpatient ☐ Outpatient

Estimated Length of Stay: _____

Letter of Agreement (LOA) Requested

Date(s) of Service: _____ 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)

STATUS	Authorization Number #
☐ Approved ☐ Modified ☐ Denied	Signature: Date:
☐ Not Medically Indicated ☐ Not a Covered Benefit	Comments:
☐ Services Available In Network	

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Special Needs Screen Questionnaire for Member with Hemophilia Transitioning from Health Networks to CalOptima Direct

☐ Hemophilia A ☐ Hemophilia B ☐ Hemophilia C ☐ von Willebrands Disease

Name: CIN #: Phone No: ( ) -

Health Network: HN Contact: Phone No: ( ) -

Primary Care Physician: Phone No: ( ) -

Treating Specialists: Phone No: ( ) -

Is Member currently in Case Management?

*If member is in case management, submit a case summary.

Planned Admissions or scheduled surgeries:

Name of Provider/Vendor: Phone No: ( ) -

Ordering Physician: Phone No: ( ) -

Date of Procedure: - - Type of Procedure:

Comments (include CPT and ICD-9 codes requested/authorized):

What factor is utilized?

Name of Provider/Vendor: Phone No: ( ) -

Ordering Physician: Phone No: ( ) -

Comments (include CPT and ICD-9 codes requested/authorized):

Has the member been hospitalized in the past six months? ☐ Yes ☐ No

If yes:

Hospital:

Diagnosis:

RX

(Please make copies of this page if additional space needed for medications)

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of person completing this form: Date: - -

PLEASE SEND A COPY OF ALL OPEN AUTHORIZATIONS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS *Check one:* ☐ Initial ☐ Re-entitlement ☐ Supplemental

1. Name *(Last, First, Middle Initial)*

2. Medicare Claim Number

3. Social Security Number

4. Date of Birth *(mm/dd/yyyy)*

5. Patient Mailing Address *(Include City, State and Zip)*

6. Phone Number *(including area code)*

7. Sex ☐ Male ☐ Female

8. Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino (Complete Item 9)

9. Country/Area of Origin or Ancestry

10. Race *(Check all that apply)*
☐ White
☐ Black or African American
☐ American Indian/Alaska Native
Print Name of Enrolled/Principal Tribe
☐ Asian
☐ Native Hawaiian or Other Pacific Islander*
*complete Item 9

11. Is patient applying for ESRD Medicare coverage? ☐ Yes ☐ No

12. Current Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance
☐ DVA ☐ Medicare Advantage ☐ Other ☐ None

13. Height INCHES ____ OR CENTIMETERS ____

14. Dry Weight POUNDS ____ OR KILOGRAMS ____

15. Primary Cause of Renal Failure *(Use ICD-10-CM Code)*

16. Employment Status *(6 mos prior and current status)*

Prior	Current	
☐	☐	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

17. Co-Morbid Conditions *(Check all that apply currently and/or during last 10 years)* *See instructions

a. ☐ Congestive heart failure
b. ☐ Atherosclerotic heart disease ASHD
c. ☐ Other cardiac disease
d. ☐ Cerebrovascular disease, CVA, TIA*
e. ☐ Peripheral vascular disease*
f. ☐ History of hypertension
g. ☐ Amputation
h. ☐ Diabetes, currently on insulin
i. ☐ Diabetes, on oral medications
j. ☐ Diabetes, without medications
k. ☐ Diabetic retinopathy
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☐ Toxic nephropathy
p. ☐ Alcohol dependence
q. ☐ Drug dependence*
r. ☐ Inability to ambulate
s. ☐ Inability to transfer
t. ☐ Needs assistance with daily activities
u. Institutionalized
☐ 1. Assisted Living
☐ 2. Nursing Home
☐ 3. Other Institution
v. ☐ Non-renal congenital abnormality
w. ☐ None

18. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
b. Was patient under care of a nephrologist? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
c. Was patient under care of kidney dietitian? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
d. What access was used on first outpatient dialysis: ___ AVF ___ Graft ___ Catheter ☐ Other
If not AVF, then: Is maturing AVF present? ☐ Yes ☐ No
Is maturing graft present? Yes No

19. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a.1. Serum Albumin (g/dl)			d. HbA1c	%	
a.2. Serum Albumin Lower Limit			e. Lipid Profile TC		
a.3. Lab Method Used (BCG or BCP)			LDL		
b. Serum Creatinine (mg/dl)			HDL		
c. Hemoglobin (g/dl)			TG		

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

20. Name of Dialysis Facility

21. Medicare Provider Number *(for item 20)*

22. Primary Dialysis Setting
☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

23. Primary Type of Dialysis
☐ Hemodialysis (Sessions per week____/hours per session____)
☐ CAPD ☐ CCPD ☐ Other

24. Date Regular Chronic Dialysis Began *(mm/dd/yyyy)*

25. Date Patient Started Chronic Dialysis at Current Facility *(mm/dd/yyyy)*

26. Has patient been informed of kidney transplant options? ☐ Yes ☐ No

27. If patient NOT informed of transplant options, please check all that apply:
☐ Medically unfit
☐ Patient has not been assessed
☐ Patient declines information
☐ Psychologically unfit
☐ Unsuitable due to age
☐ Other

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

28. Date of Transplant *(mm/dd/yyyy)*	29. Name of Transplant Hospital	30. Medicare Provider Number for Item 29

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

31. Enter Date *(mm/dd/yyyy)*	32. Name of Preparation Hospital	33. Medicare Provider number for Item 32

34. Current Status of Transplant *(if functioning, skip items 36 and 37)*	35. Type of Donor:
☐ Functioning ☐ Non-Functioning	☐ Deceased ☐ Living Related ☐ Living Unrelated
36. If Non-Functioning, Date of Return to Regular Dialysis *(mm/dd/yyyy)*	37. Current Dialysis Treatment Site
	☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

38. Name of Training Provider	39. Medicare Provider Number of Training Provider (for Item 38)
40. Date Training Began *(mm/dd/yyyy)*	41. Type of Training ☐ Hemodialysis a. ☐ Home b. ☐ In Center ☐ CAPD ☐ CCPD ☐ Other
42. This Patient is Expected to Complete *(or has completed)* Training and will Self-dialyze on a Regular Basis. ☐ Yes ☐ No	43. Date When Patient Completed, or is Expected to Complete, Training *(mm/dd/yyyy)*

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

44. Printed Name and Signature of Physician personally familiar with the patient's training			45. UPIN of Physician in Item 44
a.) Printed Name	b.) Signature	c.) Date *(mm/dd/yyyy)*	

E. PHYSICIAN IDENTIFICATION

46. Attending Physician *(Print)*	47. Physician's Phone No. *(include Area Code)*	48. UPIN of Physician in Item 46

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

49. Attending Physician's Signature of Attestation *(Same as Item 46)*	50. Date *(mm/dd/yyyy)*
51. Physician Recertification Signature	52. Date *(mm/dd/yyyy)*

53. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

54. Signature of Patient *(Signature by mark must be witnessed.)*	55. Date *(mm/dd/yyyy)*

G. PRIVACY STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-70-0520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the *Federal Register* notice cited above. You should be aware that P.L.100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

INSTRUCTIONS FOR COMPLETION OF END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

For whom should this form be completed:

This form SHOULD NOT be completed for those patients who are in acute renal failure. Acute renal failure is a condition in which kidney function can be expected to recover after a short period of dialysis, i.e., several weeks or months.

This form MUST BE completed within 45 days for ALL patients beginning any of the following:

Check the appropriate block that identifies the reason for submission of this form.

Initial

For all patients who initially receive a kidney transplant instead of a course of dialysis. For patients for whom a regular course of dialysis has been prescribed by a physician because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life. The first date of a regular course of dialysis is the date this prescription is implemented whether as an inpatient of a hospital, an outpatient in a dialysis center or facility, or a home patient.

The form should be completed for all patients in this category even if the patient dies within this time period.

Re-entitlement

For beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post- transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.

For beneficiaries who stopped dialysis for more than 12 months, have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant. These patients will be reapplying for Medicare ESRD benefits.

Supplemental

Patient has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

All items except as follows: To be completed by the attending physician, head nurse, or social worker involved in this patient's treatment of renal disease.

Items 15, 17-18, 26-27, 49-50: To be completed by the attending physician.
Item 44: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.
Items 54 and 55: To be signed and dated by the patient.

1. Enter the patient's legal name (Last, first, middle initial). Name should appear exactly the same as it appears on patient's social security or Medicare card.
2. If the patient is covered by Medicare, enter his/her Medicare claim number as it appears on his/her Medicare card.
3. Enter the patient's own social security number. This number can be verified from his/her social security card.
4. Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
5. Enter the patient's mailing address (number and street or post office box number, city, state, and ZIP code.)
6. Enter the patient's home area code and telephone number.
7. Check the appropriate block to identify sex.
8. Check the appropriate block to identify ethnicity. Definitions of the ethnicity categories for Federal statistics are as follows:

   Not Hispanic or Latino—A person of culture or origin not described below, regardless of race.

   Hispanic or Latino—A person of Cuban, Puerto Rican, or Mexican culture or origin regardless of race. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.
9. Country/Area of origin or ancestry—Complete if information is available or if directed to do so in question 8.
10. Check the appropriate block(s) to identify race. Definitions of the racial categories for Federal statistics are as follows:

    White—A person having origins in any of the original white peoples of Europe, the Middle East or North Africa.

    Black or African American—A person having origins in any of the black racial groups of Africa. This includes native-born Black Americans, Africans, Haitians and residents of non-Spanish speaking Caribbean Islands of African descent.

    American Indian/Alaska Native—A person having origins in any of the original peoples of North America and South America (including Central America) and who maintains Tribal affiliation or community attachment. Print the name of the enrolled or principal tribe to which the patient claims to be a member.

    Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

    Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.

DISTRIBUTION OF COPIES:

- Forward one copy of this form to the Social Security office servicing the claim.
- Forward one copy of this form to the ESRD Network Organization.
- Retain one copy of this form in the patient's medical records file.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0046. The time required to complete this information collection estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attention: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

11. Check the appropriate yes or no block to indicate if patient is applying for ESRD Medicare. Note: Even though a person may already be entitled to general Medicare coverage, he/she should reapply for ESRD Medicare coverage.

12. Check all the blocks that apply to this patient's current medical insurance status.

Medicaid—Patient is currently receiving State Medicaid benefits.

Medicare—Patient is currently entitled to Federal Medicare benefits.

Employer Group Health Insurance—Patient receives medical benefits through an employee health plan that covers employees, former employees, or the families of employees o former employees.

DVA—Patient is receiving medical care from a Department of Veterans Affairs facility.

Medicare Advantage—Patient is receiving medical benefits under a Medicare Advantage organization.

Other Medical Insurance—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, HMO/M+C organization, nor an employer group health insurance plan. Examples of other medical insurance are Railroad Retirement and CHAMPUS beneficiaries.

None—Patient has no medical insurance plan.

13. Enter the patient's most recent recorded height in inches OR centimeters at time form is being completed. If entering height in centimeters, round to the nearest centimeter. Estimate or use last known height for those unable to be measured. (Example of inches - 62. DO NOT PUT 5'2") NOTE: For amputee patients, enter height prior to amputation.

14. Enter the patient's most recent recorded dry weight in pounds OR kilograms at time form is being completed. If entering weight in kilograms, round to the nearest kilogram.

NOTE: For amputee patients, enter actual dry weight.

15. To be completed by the attending physician. Enter the ICD10-CM Code to indicate the primary cause of end stage renal disease.

16. Check the first box to indicate employment status 6 months prior to renal failure and the second box to indicate current employment status. Check only one box for each time period. If patient is under 6 years of age, leave blank.

17. To be completed by the attending physician. Check all co-morbid conditions that apply.

*Cerebrovascular Disease includes history of stroke/cerebrovascular accident (CVA) and transient ischemic attack (TIA).

*Peripheral Vascular Disease includes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.

*Drug dependence means dependent on illicit drugs.

18. Prior to ESRD therapy, check the appropriate box to indicate whether the patient received exogenous erythropoietin (EPO) or equivalent, was under the care of a nephrologist and/or was under the care of a kidney dietitian. Provide vascular access information as to the type of access used (Arterio-Venous Fistula (AVF), graft, catheter (including port device) or other type of access) when the patient first received outpatient dialysis. If an AVF access was not used, was a maturing AVF or graft present?

NOTE: For those patients re-entering the Medicare program after benefits were terminated, Items 19a thru 19c should contain initial laboratory values within 45 days prior to the most recent ESRD episode. Lipid profiles and HbA1c should be within 1 year of the most recent ESRD episode. Some tests may not be required for patients under 21 years of age.

19a1. Enter the serum albumin value (g/dl) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or kidney transplant.

19a2. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in 19a1.

19a3. Enter the serum albumin lab method used (BCG or BCP).

19b. Enter the serum creatinine value (mg/dl) and date test was taken. THIS FIELD MUST BE COMPLETED. Value must be within 45 days prior to first dialysis treatment or kidney transplant.

19c. Enter the hemoglobin value (g/dl) and date test was taken. This value and date must be within 45 days prior to the first dialysis treatment or kidney transplant.

19d. Enter the HbA1c value and the date the test was taken. The date must be within 1 year prior to the first dialysis treatment or kidney transplant.

19e. Enter the Lipid Profile values and date test was taken. These values: TC–Total Cholesterol; LDL–LDL Cholesterol; HDL–HDL Cholesterol; TG–Triglycerides, and date must be within 1 year prior to the first dialysis treatment or kidney transplant.

20. Enter the name of the dialysis facility where patient is currently receiving care and who is completing this form for patient.

21. Enter the 6-digit Medicare identification code of the dialysis facility in item 20.

22. If the person is receiving a regular course of dialysis treatment, check the appropriate anticipated long-term treatment setting at the time this form is being completed.

23. If the patient is, or was, on regular dialysis, check the anticipated long-term primary type of dialysis: Hemodialysis, (enter the number of sessions prescribed per week and the hours that were prescribed for each session), CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis), or Other. Check only one block. NOTE: Other has been placed on this form to be used only to report IPD (Intermittent Peritoneal Dialysis) and any new method of dialysis that may be developed prior to the renewal of this form by Office of Management and Budget.

24. Enter the date (month, day, year) that a "regular course of chronic dialysis" began. The beginning of the course of dialysis is counted from the beginning of regularly scheduled dialysis necessary for the treatment of end stage renal disease (ESRD) regardless of the dialysis setting. The date of the first dialysis treatment after the physician has determined that this patient has ESRD and has written a prescription for a "regular course of dialysis" is the "Date Regular Chronic Dialysis Began" regardless of whether this prescription was implemented in a hospital/ inpatient, outpatient, or home setting and regardless of any acute treatments received prior to the implementation of the prescription.

NOTE: For these purposes, end stage renal disease means irreversible damage to a person's kidneys so severely affecting his/her ability to remove or adjust blood wastes that in order to maintain life he or she must have either a course of dialysis or a kidney transplant to maintain life.

If re-entering the Medicare program, enter beginning date of the current ESRD episode. Note in Remarks, Item 53, that patient is restarting dialysis.

25. Enter date patient started chronic dialysis at current facility of dialysis services. In cases where patient transferred to current dialysis facility, this date will be after the date in Item 24.

26. Enter whether the patient has been informed of their options for receiving a kidney transplant.

27. If the patient has not been informed of their options (answered "no" to Item 26), then enter all reasons why a

kidney transplant was not an option for this patient at this time.

28. Enter the date(s) of the patient's kidney transplant(s). If reentering the Medicare program, enter current transplant date.
29. Enter the name of the hospital where the patient received a kidney transplant on the date in Item 28.
30. Enter the 6-digit Medicare identification code of the hospital in Item 29 where the patient received a kidney transplant on the date entered in Item 28.
31. Enter date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation. This includes hospitalization for transplant workup in order to place the patient on a transplant waiting list.
32. Enter the name of the hospital where patient was admitted as an inpatient in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation.
33. Enter the 6-digit Medicare identification number for hospital in Item 32.
34. Check the appropriate functioning or non-functioning block.
35. Enter the type of kidney transplant organ donor, Deceased, Living Related or Living Unrelated, that was provided to the patient.
36. If transplant is nonfunctioning, enter date patient returned to a regular course of dialysis. If patient did not stop dialysis post-transplant, enter transplant date.
37. If applicable, check where patient is receiving dialysis treatment following transplant rejection. A nursing home or skilled nursing facility is considered as home setting

Self-dialysis Training Patients (Medicare Applicants Only)

Normally, Medicare entitlement begins with the third month after the month a patient begins a regular course of dialysis treatment. This 3-month qualifying period may be waived if a patient begins a self-dialysis training program in a Medicare approved training facility and is expected to self-dialyze after the completion of the training program. Please complete items 38-43 if the patient has entered into a self-dialysis training program. Items 38-43 must be completed if the patient is applying for a Medicare waiver of the 3-month qualifying period for dialysis benefits based on participation in a self-care dialysis training program.

38. Enter the name of the provider furnishing self-care dialysis training.
39. Enter the 6-digit Medicare identification number for the training provider in Item 38.
40. Enter the date self-dialysis training began.
41. Check the appropriate block which describes the type of self-care dialysis training the patient began. If the patient trained for hemodialysis, enter whether the training was to perform dialysis in the home setting or in the facility (in center). If the patient trained for IPD (Intermittent Peritoneal Dialysis), report as Other.
42. Check the appropriate block as to whether or not the physician certifies that the patient is expected to complete the training successfully and self-dialyze on a regular basis.
43. Enter date patient completed or is expected to complete self-dialysis training.
44. Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.
45. Enter the Unique Physician Identification Number (UPIN) of physician in Item 44. (See Item 48 for explanation of UPIN.)
46. Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.
47. Enter the area code and telephone number of the physician who is supervising the patient's renal treatment at the time this form is completed.
48. Enter the physician's UPIN assigned by CMS.

    A system of physician identifiers is mandated by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985. It requires a unique identifier for each physician who provides services for which Medicare payment is made. An identifier is assigned to each physician regardless of his or her practice configuration. The UPIN is established in a national Registry of Medicare Physician Identification and Eligibility Records (MPIER). Transamerica Occidental Life Insurance Company is the Registry Carrier that establishes and maintains the national registry of physicians receiving Part Medicare payment. Its address is: UPIN Registry, Transamerica Occidental Life, P.O. Box 2575, Los Angeles, CA 90051-0575.
49. To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in Item 46. A stamped signature is unacceptable.
50. Enter date physician signed this form.
51. To be signed by the physician who is currently following the patient. If the patient had decided initially not to file an application for Medicare, the physician will be re-certifying that the patient is end stage renal, based on the same medical evidence, by signing the copy of the CMS-2728 that was originally submitted and returned to the provider. If you do not have a copy of the original CMS-2728 on file, complete a new form.
52. The date physician re-certified and signed the form.
53. This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office.
54. The patient's signature authorizing the release of information to the Department of Health and Human Services must be secured here. If the patient is unable to sign the form, it should be signed by a relative, a person assuming responsibility for the patient or by a survivor.
55. The date patient signed form.

Policy #:	DD.2008
Title:	**Health Network and CalOptima Community Network Selection Process**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/1995
~~Last Review Date:~~	~~06/01/18~~
~~Last~~ Revised Date:	~~06/01/18~~04/04/2019

I. PURPOSE

This policy describes the process by which a Health Network Eligible Member shall select **CalOptima Community Network (CCN)** or a Health Network, and **CCN's** or the Health Network's responsibilities for such Member.

II. POLICY

A. CalOptima is committed to a Health Network Eligible Member's right to choose **CCN** or a Health Network. CalOptima also recognizes that it is in the best interest of a Member to establish a medical home and maintain Continuity **of** Care with a **Primary Care Provider (PCP)**.

B. CalOptima shall request a Health Network Eligible Member select **CCN** or a Health Network, in accordance with the terms and conditions of this policy.

1. Except as otherwise provided in this policy, a Health Network Eligible Member may select **CCN** or any Health Network that is accepting new Members.

2. Effective January 1, 2007, only a Member who is less than twenty-one (21) years of age may enroll in CHOC Health Alliance, as set forth in Section III.B of this policy.

3. On or after the effective date of the CalOptima Whole-Child Model program, a **member** who is known to be participating in California's Children Services (CCS) may only enroll in a **health network** that is participating in the Whole-Child Model program.

C. A Health Network Eligible Member who does not select **CCN** or a Health Network shall be subject to the Auto-Assignment process, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

D. CalOptima recognizes that Family Linked Members may be best served by a single Health Network to ensure coordinated delivery of services by a Provider who is knowledgeable about the diverse needs of all of the Members in the family. To facilitate this objective, CalOptima shall assign a Family Linked Member whose family includes a Member already enrolled in a Health Network or **CCN**, to that Health Network or **CCN**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

1. On and after January 1, 2007, except as otherwise provided in this policy, CalOptima shall assign a Family Linked Member to the same Health Network as his or her youngest sibling if such Family Linked Member is under the age of twenty-one (21) years~~.~~.

2. If a Family Linked Member is over the age of twenty-one (21) years and his or her youngest sibling is enrolled in CHOC Health Alliance, CalOptima shall assign the Family Linked Member to the Health Network of another family **member**, if applicable.

3. On or after the effective date of the CalOptima Whole-Child Model program, if the **member** is known to be eligible with the Whole-Child Model program/**California Children Services Program (CCS)** and the **member's** youngest sibling is assigned to a **health network** that does not participate in the WCM/**CCS** program, the Family Link process will not apply.

E. A Health Network Eligible Member may change his or her Health Network or select **CCN** for any reason every thirty (30) calendar days, in accordance with this policy.

F. **CCN** or a Health Network shall be responsible for providing Covered Services to its Members, in accordance with its contract and applicable statutes, regulations, CalOptima policies, and other requirements of the CalOptima program.

1. If a Health Network Eligible Member moves outside of Orange County, his or her Health Network shall remain responsible for all Covered Services until the Member is no longer enrolled in the CalOptima program. If a Health Network Eligible Member becomes the responsibility of the Public Administrator/Public Guardian or is in an Institute for Mental Disease and is placed outside of Orange County, his or her Health Network shall continue to be responsible for all Covered Services until the Health Network or the Public Administrator /Public Guardian submits a request to enroll the Member in CalOptima Direct, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

2. If a Member becomes the responsibility of the Foster Care Program, **CCN** or his or her Health Network shall remain responsible for all Covered Services. The Member's foster parent, legal guardian, or the Orange County ~~Children's~~Children & Family Services Department may request to transition the Member into **CalOptima Direct (COD) – Administrative (COD-A)**, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

G. **CCN** or a Health Network shall not be responsible for Covered Services provided to a Member outside the United States with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22 of the California Code of Regulations, Section 51006.

H. CalOptima or a Health Network shall ensure Continuity **of** Care for Members who transition into CalOptima in accordance with CalOptima Policy GG.1325: Coordination of Care for ~~Newly Enrolled Medi-Cal~~ Members Transitioning into CalOptima Services.

I. In the event that a **member** is required to change **health network**s, due to **health network** termination or participation status of a **health network** in the Whole-Child Model program, CalOptima and the receiving **health network** shall collaborate to coordinate the provision of **covered services** for the affected **member**, in accordance with CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination.

III. PROCEDURE

Back to Agenda

A. **CCN** or **Health Network** Selection Process

1. Upon receipt of the Member's eligibility information from the Department of Health Care Services (DHCS), CalOptima shall send an enrollment packet to a Health Network Eligible Member. The enrollment packet shall include, but not be limited to, the following information:

   a. Introductory/welcome letter;

   b. CalOptima **Health Network** Selection Form;

   c. Health Information Form;

   d. CalOptima **Member** Handbook;

   e. CalOptima **Member** Identification Card;

   f. Invitation to a **Member** orientation;

   g. **Health Network** report card;

   h. **Health Network** Listing and Provider Directory; and

   i. Postage-paid envelope to return materials to CalOptima.

2. Only a Health Network Eligible Member or the Member's Authorized Representative shall sign a Health Network Selection Form on behalf of the Member. CalOptima shall not accept a **Health Network** Selection Form submitted without the signature of the Member or an Authorized Representative.

   a. CalOptima shall not accept responsibility for an inappropriately signed **Health Network** Selection Form.

3. CalOptima realizes that in some instances, such as time-sensitive health care appointments or challenges with valid home addresses, it is in the best interest of the Member to allow a change of Health Network or **CCN** selection request to be made by the Member or the Member's Authorized Representative over the phone~~.~~ in accordance with CalOptima Policy DD.2006b:CalOptima Community Network Member Primary Care Provider Selection/Assignment. In those circumstances, the request will be recorded and processed by the Customer Service Representative at the time of request.

4. If CalOptima receives a Health Network Eligible Member's completed **Health Network** Selection Form by the tenth (10th) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1st) calendar day of the immediately following month. If CalOptima receives a Member's completed **Health Network** Selection Form after the tenth (10th) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1st) calendar day of the month after the immediately following month.

5. A Health Network Eligible Member who has not selected a Health Network or **CCN** within the designated timeframe shall be automatically assigned to a Health Network pursuant to CalOptima Policy AA.1207a: CalOptima Auto-Assignment. Following the assignment of a ~~Health Network Eligible~~ Member in accordance with this policy, CalOptima shall notify the Member in writing of the assignment.

6. CalOptima may apply the following criteria to Member assignments to Health Networks or **CCN**:

   a. Consistent with the provisions of this policy and CalOptima Policy AA.1207a: CalOptima Auto-Assignment Policy, CalOptima shall assign Family Linked Members to the same Health Network or **CCN**.

   b. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility less than three hundred sixty-five (365) calendar days, CalOptima shall assign the Health Network Eligible Member to **CCN** or the last Health Network to which the Member was enrolled.

   c. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility more than three hundred sixty-five (365) calendar days, CalOptima shall treat such Health Network Eligible Member as a new Member, in accordance with this policy.

7. If a Health Network contract with CalOptima is terminated, ~~a Member~~or a health network is no longer participating in the Whole-Child Model Program a **member** who is enrolled in that Health Network may choose a new Health Network or **CCN**, in accordance with this policy.

   a. If the Member does not select a new Health Network or **CCN** prior to the contract termination of the Member's current Health Network, CalOptima shall assign such Member to:

      i. A Health Network of the Member's **PCP**'s choice if the Member's **PCP**, as shown in CalOptima's system, is contracted with at least one (1) other Health Network; or

      ii. A Health Network based on Auto Assignment.

8. A Health Network Eligible Member may change his or her **PCP** every thirty (30) calendar days for any reason~~. A Health Network or CCN shall process a Health Network Eligible Member's request to change his or her PCP.~~

B. **Member**s eligible for enrollment in CHOC Health Alliance

1. ~~A Member~~Subject to other limitations set forth in this policy, a **member** who meets criteria set forth in Section II.B.2 of this policy may select CHOC Health Alliance.

2. CalOptima shall assign a new Health Network Eligible Member to CHOC Health Alliance, in accordance with Policy AA.1207a: CalOptima Auto-Assignment.

3. Except as otherwise provided in Section ~~H~~III.B.4 of this policy, a 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 the following:

    a. CalOptima shall provide the Member with a ninety (90), sixty (60) and thirty (30) calendar day written notice to select **CCN** or another Health Network prior to the Member's twenty-first (21st) birthday. The written notices shall inform the Member that CHOC will only provide health care service until the end of the Member's twenty-first (21st) birth month.

    b. If the Member does not select **CCN** or another Health Network within the designated timeframe, CalOptima shall assign the Member to **CCN** or a Health Network as follows:

        i. If the Member's **PCP** is contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network of the Member's **PCP**'s choice; or

        ii. If the Member's **PCP** is not contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network based on geographic access.

    c. The Member shall be enrolled in **CCN** or the new Health Network effective the first (1st) calendar day of the month immediately following the Member's twenty-first (21st) birthday.

4. A Member shall remain in CHOC Health Alliance beyond the Member's twenty-first (21st) birthday if the Member meets all of the following criteria:

    a. **Member** is diagnosed with one (1) of the following **California Children's Services (CCS)**-Eligible Conditions:

        i. Cystic Fibrosis;

        ii. A rare metabolic ~~disorders~~disorder not including Phenylketonuria (PKU);

        iii. Spina Bifida; or

        iv. Muscular Dystrophy.

    b. **Member** is eligible to receive services from **CCS** for the **CCS**-Eligible Condition as of the day before the Member's twenty-first (21st) birthday; and

    c. **Member** is receiving care for the **CCS**-Eligible Condition from a pediatric specialist who is contracted with CHOC Health Alliance as of the day before the Member's twenty-first (21st) birthday.

    d. A Member who remains in CHOC Health Alliance pursuant to Section III.B.4.a of this policy shall remain in CHOC Health Alliance until:

        i. The Member selects **CCN** or another Health Network; or

ii. The Member's pediatric specialist determines that the Member's care may safely be transitioned to **CCN** or another Health Network.

~~5. CalOptima and CHOC Health Alliance shall begin developing a transition plan for a Member who is enrolled in CHOC Health Alliance and who has a CCS-Eligible Condition no later than the Member's twentieth (20th) birthday, in accordance with CalOptima Policy GG.1101: California Children's Services.~~

C. If a Health Network Eligible Member moves outside of Orange County, the Member's Health Network or **CCN** shall continue to be responsible for Covered Services until the Member is no longer enrolled in the CalOptima program.

1. Upon notice that a Health Network Eligible Member has moved outside of Orange County, **CCN** or a Health Network shall attempt to verify this information with the Member. **CCN** or the Health Network shall instruct the Member to contact the County of Orange Social Services Agency or the United States Social Security Administration to report a change of address.

2. A Health Network or **CCN provider** shall notify CalOptima of a Health Network Eligible Member's change of address by submitting a Medi-Cal Contact Information Request Form (MC 354) to the CalOptima Customer Service Department.

3. Upon notice that a Health Network Eligible Member has moved out of Orange County, CalOptima shall send the Member's new residence information to the County of Orange Social Services Agency, in accordance with Title 22 of the California Code of Regulations, Section 50188, or to the U.S. Social Security Administration.

D. CalOptima recognizes that a situation may occur in which the needs of a Family Linked Member may not be best served by enrollment in the same Health Network as other Members in his or her family in accordance with Section II.D of this policy. A Family Linked Member may contact CalOptima's Customer Service Department to request enrollment in **CCN** or a different Health Network from other Members in his or her family.

IV. ATTACHMENTS

A. Health Network Selection Form
B. CalOptima Introductory Letter

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
~~D.~~E. CalOptima Policy GG.1101: California Children's Services
F. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
~~E.~~G. CalOptima Policy GG.1325: Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima

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~~F.~~H. Contract for Health Care Services
~~G.~~I. Medi-Cal Managed Care Division (MMCD) All-Plan Letter (APL) 03-002: SB 87 Medi-Cal Contact Information Release Form
~~H.~~J. Title 22, California Code of Regulations, §§50188, 51006, and 51301 et seq.

VI. REGULATORY AGENCY APPROVALS

A. 11/09/17: Department of Health Care Services
B. 06/24/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 08/07/14: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 10/03/06: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 08/30/06: Special Meeting of the CalOptima Board of Directors

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VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	10/01/1995	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	02/20/1997	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	07/01/2004	DD.1114	Request from Members of Same Household to Enroll in Different Health Networks	Medi-Cal
Revised	09/01/2004	DD.1109	Health Network Selection and Health Network Obligations for Members	Medi-Cal
Revised	01/01/2007	DD.2008	Health Network Selection Process	Medi-Cal
Revised	01/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	12/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	03/01/2015	DD.2008	Health Network Selection Process	Medi-Cal
Revised	04/01/2016	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2017	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2018	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal
Revised	04/04/2019	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal

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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 (21) years who have CCS ~~Eligible Conditions~~eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the ~~Members~~members.
CalOptima Direct – Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CCS-Eligible Conditions	~~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~~, Section 41800~~ sections 41515.2 through ~~4187.6 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 Accidents, poisonings, violence, and immunization reactions~~41518.9..
Continuity of Care	Services provided to a ~~Member~~member rendered by an out-of-network provider with whom the ~~Member~~member has pre-existing provider relationship.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as ~~Covered Services~~covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51310 of Title 22, CCR), which shall be covered for ~~Members~~members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Family Linked Member	A ~~Member~~member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another ~~Member~~member who is in his or her family and who resides in the same household.
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~~covered services to ~~Members~~members assigned to that ~~Health Network~~health network.
Health Network Eligible Member	A ~~Member~~member who is eligible to choose a CalOptima ~~Health Network~~health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members.
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.~~covered services.

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Policy #:	DD.2008
Title:	**Health Network and CalOptima Community Network Selection Process**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/1995
Revised Date:	04/04/2019

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3. On or after the effective date of the CalOptima Whole-Child Model program, a **member** who is known to be participating in California's Children Services (CCS) may only enroll in a **health network** that is participating in the Whole-Child Model program.

C. A Health Network Eligible Member who does not select **CCN** or a Health Network shall be subject to the Auto-Assignment process, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

D. CalOptima recognizes that Family Linked Members may be best served by a single Health Network to ensure coordinated delivery of services by a Provider who is knowledgeable about the diverse needs of all of the Members in the family. To facilitate this objective, CalOptima shall assign a Family Linked Member whose family includes a Member already enrolled in a Health Network or **CCN**, to that Health Network or **CCN**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

1. On and after January 1, 2007, except as otherwise provided in this policy, CalOptima shall assign a Family Linked Member to the same Health Network as his or her youngest sibling if such Family Linked Member is under the age of twenty-one (21) years.

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2. If a Family Linked Member is over the age of twenty-one (21) years and his or her youngest sibling is enrolled in CHOC Health Alliance, CalOptima shall assign the Family Linked Member to the Health Network of another family **member**, if applicable.

3. On or after the effective date of the CalOptima Whole-Child Model program, if the **member** is known to be eligible with the Whole-Child Model program/**California Children Services Program (CCS)** and the **member's** youngest sibling is assigned to a **health network** that does not participate in the WCM/**CCS** program, the Family Link process will not apply.

E. A Health Network Eligible Member may change his or her Health Network or select **CCN** for any reason every thirty (30) calendar days, in accordance with this policy.

F. **CCN** or a Health Network shall be responsible for providing Covered Services to its Members, in accordance with its contract and applicable statutes, regulations, CalOptima policies, and other requirements of the CalOptima program.

1. If a Health Network Eligible Member moves outside of Orange County, his or her Health Network shall remain responsible for all Covered Services until the Member is no longer enrolled in the CalOptima program. If a Health Network Eligible Member becomes the responsibility of the Public Administrator/Public Guardian or is in an Institute for Mental Disease and is placed outside of Orange County, his or her Health Network shall continue to be responsible for all Covered Services until the Health Network or the Public Administrator /Public Guardian submits a request to enroll the Member in CalOptima Direct, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

2. If a Member becomes the responsibility of the Foster Care Program, **CCN** or his or her Health Network shall remain responsible for all Covered Services. The Member's foster parent, legal guardian, or the Orange County Children & Family Services Department may request to transition the Member into **CalOptima Direct (COD) – Administrative (COD-A)**, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

G. **CCN** or a Health Network shall not be responsible for Covered Services provided to a Member outside the United States with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22 of the California Code of Regulations, Section 51006.

H. CalOptima or a Health Network shall ensure Continuity **of** Care for Members who transition into CalOptima in accordance with CalOptima Policy GG.1325: Coordination of Care for Members Transitioning into CalOptima Services.

I. In the event that a **member** is required to change **health network**s, due to **health network** termination or participation status of a **health network** in the Whole-Child Model program, CalOptima and the receiving **health network** shall collaborate to coordinate the provision of **covered services** for the affected **member**, in accordance with CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination.

III. PROCEDURE

A. **CCN** or **Health Network** Selection Process

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1. Upon receipt of the Member's eligibility information from the Department of Health Care Services (DHCS), CalOptima shall send an enrollment packet to a Health Network Eligible Member. The enrollment packet shall include, but not be limited to, the following information:

    a. Introductory/welcome letter;

    b. CalOptima **Health Network** Selection Form;

    c. Health Information Form;

    d. CalOptima **Member** Handbook;

    e. CalOptima **Member** Identification Card;

    f. Invitation to a **Member** orientation;

    g. **Health Network** report card;

    h. **Health Network** Listing and Provider Directory; and

    i. Postage-paid envelope to return materials to CalOptima.

2. Only a Health Network Eligible Member or the Member's Authorized Representative shall sign a Health Network Selection Form on behalf of the Member. CalOptima shall not accept a **Health Network** Selection Form submitted without the signature of the Member or an Authorized Representative.

    a. CalOptima shall not accept responsibility for an inappropriately signed **Health Network** Selection Form.

3. CalOptima realizes that in some instances, such as time-sensitive health care appointments or challenges with valid home addresses, it is in the best interest of the Member to allow a change of Health Network or **CCN** selection request to be made by the Member or the Member's Authorized Representative over the phone in accordance with CalOptima Policy DD.2006b:CalOptima Community Network Member Primary Care Provider Selection/Assignment. In those circumstances, the request will be recorded and processed by the Customer Service Representative at the time of request.

4. If CalOptima receives a Health Network Eligible Member's completed **Health Network** Selection Form by the tenth (10th) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1st) calendar day of the immediately following month. If CalOptima receives a Member's completed **Health Network** Selection Form after the tenth (10th) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1st) calendar day of the month after the immediately following month.

5. A Health Network Eligible Member who has not selected a Health Network or **CCN** within the designated timeframe shall be automatically assigned to a Health Network pursuant to CalOptima Policy AA.1207a: CalOptima Auto-Assignment. Following the assignment of a Member in accordance with this policy, CalOptima shall notify the Member in writing of the assignment.

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6. CalOptima may apply the following criteria to Member assignments to Health Networks or **CCN**:

    a. Consistent with the provisions of this policy and CalOptima Policy AA.1207a: CalOptima Auto-Assignment Policy, CalOptima shall assign Family Linked Members to the same Health Network or **CCN**.

    b. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility less than three hundred sixty-five (365) calendar days, CalOptima shall assign the Health Network Eligible Member to **CCN** or the last Health Network to which the Member was enrolled.

    c. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility more than three hundred sixty-five (365) calendar days, CalOptima shall treat such Health Network Eligible Member as a new Member, in accordance with this policy.

7. If a Health Network contract with CalOptima is terminated, or a health network is no longer participating in the Whole-Child Model Program a **member** who is enrolled in that Health Network may choose a new Health Network or **CCN**, in accordance with this policy.

    a. If the Member does not select a new Health Network or **CCN** prior to the contract termination of the Member's current Health Network, CalOptima shall assign such Member to:

        i. A Health Network of the Member's **PCP**'s choice if the Member's **PCP**, as shown in CalOptima's system, is contracted with at least one (1) other Health Network; or

        ii. A Health Network based on Auto Assignment.

8. A Health Network Eligible Member may change his or her **PCP** every thirty (30) calendar days for any reason

B. **Member**s eligible for enrollment in CHOC Health Alliance

1. Subject to other limitations set forth in this policy, a **member** who meets criteria set forth in Section II.B.2 of this policy may select CHOC Health Alliance.

2. CalOptima shall assign a new Health Network Eligible Member to CHOC Health Alliance, in accordance with Policy AA.1207a: CalOptima Auto-Assignment.

3. Except as otherwise provided in Section III.B.4 of this policy, a 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 the following:

    a. CalOptima shall provide the Member with a ninety (90), sixty (60) and thirty (30) calendar day written notice to select **CCN** or another Health Network prior to the Member's twenty-first (21st) birthday. The written notices shall inform the Member that CHOC will only provide health care service until the end of the Member's twenty-first (21st) birth month.

    b. If the Member does not select **CCN** or another Health Network within the designated timeframe, CalOptima shall assign the Member to **CCN** or a Health Network as follows:

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i. If the Member's **PCP** is contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network of the Member's **PCP**'s choice; or

ii. If the Member's **PCP** is not contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network based on geographic access.

c. The Member shall be enrolled in **CCN** or the new Health Network effective the first (1st) calendar day of the month immediately following the Member's twenty-first (21st) birthday.

4. A Member shall remain in CHOC Health Alliance beyond the Member's twenty-first (21st) birthday if the Member meets all of the following criteria:

a. **Member** is diagnosed with one (1) of the following **California Children's Services (CCS)-**Eligible Conditions:

i. Cystic Fibrosis;

ii. A rare metabolic disorder not including Phenylketonuria (PKU);

iii. Spina Bifida; or

iv. Muscular Dystrophy.

b. **Member** is eligible to receive services from **CCS** for the **CCS**-Eligible Condition as of the day before the Member's twenty-first (21st) birthday; and

c. **Member** is receiving care for the **CCS**-Eligible Condition from a pediatric specialist who is contracted with CHOC Health Alliance as of the day before the Member's twenty-first (21st) birthday.

d. A Member who remains in CHOC Health Alliance pursuant to Section III.B.4.a of this policy shall remain in CHOC Health Alliance until:

i. The Member selects **CCN** or another Health Network; or

ii. The Member's pediatric specialist determines that the Member's care may safely be transitioned to **CCN** or another Health Network.

C. If a Health Network Eligible Member moves outside of Orange County, the Member's Health Network or **CCN** shall continue to be responsible for Covered Services until the Member is no longer enrolled in the CalOptima program.

1. Upon notice that a Health Network Eligible Member has moved outside of Orange County, **CCN** or a Health Network shall attempt to verify this information with the Member. **CCN** or the Health Network shall instruct the Member to contact the County of Orange Social Services Agency or the United States Social Security Administration to report a change of address.

2. A Health Network or **CCN provider** shall notify CalOptima of a Health Network Eligible Member's change of address by submitting a Medi-Cal Contact Information Request Form (MC 354) to the CalOptima Customer Service Department.

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3. Upon notice that a Health Network Eligible Member has moved out of Orange County, CalOptima shall send the Member's new residence information to the County of Orange Social Services Agency, in accordance with Title 22 of the California Code of Regulations, Section 50188, or to the U.S. Social Security Administration.

D. CalOptima recognizes that a situation may occur in which the needs of a Family Linked Member may not be best served by enrollment in the same Health Network as other Members in his or her family in accordance with Section II.D of this policy. A Family Linked Member may contact CalOptima's Customer Service Department to request enrollment in **CCN** or a different Health Network from other Members in his or her family.

IV. ATTACHMENTS

A. Health Network Selection Form
B. CalOptima Introductory Letter

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
E. CalOptima Policy GG.1101: California Children's Services
F. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
G. CalOptima Policy GG.1325: Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima
H. Contract for Health Care Services
I. Medi-Cal Managed Care Division (MMCD) All-Plan Letter (APL) 03-002: SB 87 Medi-Cal Contact Information Release Form
J. Title 22, California Code of Regulations, §§50188, 51006, and 51301 et seq.

VI. REGULATORY AGENCY APPROVALS

A. 11/09/17: Department of Health Care Services
B. 06/24/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
B. 08/07/14: Regular Meeting of the CalOptima Board of Directors
C. 10/03/06: Regular Meeting of the CalOptima Board of Directors
D. 08/30/06: Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	02/20/1997	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	07/01/2004	DD.1114	Request from Members of Same Household to Enroll in Different Health Networks	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2004	DD.1109	Health Network Selection and Health Network Obligations for Members	Medi-Cal
Revised	01/01/2007	DD.2008	Health Network Selection Process	Medi-Cal
Revised	01/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	12/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	03/01/2015	DD.2008	Health Network Selection Process	Medi-Cal
Revised	04/01/2016	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2017	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2018	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal
Revised	04/04/2019	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal

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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.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the members.
CalOptima Direct – Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CCS-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..
Continuity of Care	Services provided to a member rendered by an out-of-network provider with whom the member has pre-existing provider relationship.
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 51310 of Title 22, CCR), which shall be covered for members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Family Linked Member	A member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another member who is in his or her family and who resides in the same household.
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.
Health Network Eligible Member	A member who is eligible to choose a CalOptima health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members.

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.

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PRI-037-105

CalOptima
A Public Agency
Better. Together.

HEALTH NETWORK (HN) SELECTION FORM

MEMBER NAME AND ID #			1 CHOOSE A PRIMARY CARE PROVIDER (PCP)			2 CHOOSE A HN
Last:	First:	ID #:	PCP Last Name or Clinic Name:	PCP First Name:	PCP or Clinic ID:	HN ID*

*Please see your *Health Network Selection Form Guide* for a list of Health Network IDs (HN IDs).
Consulte la *Guía para llenar el Formulario de Selección de Planes de Salud* para una lista de los números de identificación de los planes de salud (HN IDs).
Xin xem *Tài Liệu Hướng Dẫn Điền Mẫu Đơn Chọn Nhóm Y Tế* để biết danh sách Số ID của Các Nhóm Y Tế (Health Network IDs viết tắt là HN IDs).
لطفاً به راهنمای فرم انتخاب شبکه بهداشتی خود برای فهرست شماره شناسایی شبکه های بهداشتی (HN IDs) مراجعه کنید.

3 IMPORTANT! SIGN AND DATE BELOW. THIS FORM MUST BE SIGNED!

Signature of Member or Legal Representative: X _____ Date: _____

Telephone Number: ( ) – Cell Phone Number: ( ) –

E-mail Address:

Do you have insurance other than Medi-Cal / CalOptima? Yes No If Yes, Insurance Name: Policy Number:

NEED HELP? PLEASE CALL CALOPTIMA'S CUSTOMER SERVICE DEPARTMENT AT 1-714-246-8500 OR TOLL-FREE AT 1-888-587-8088

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Dear Member:

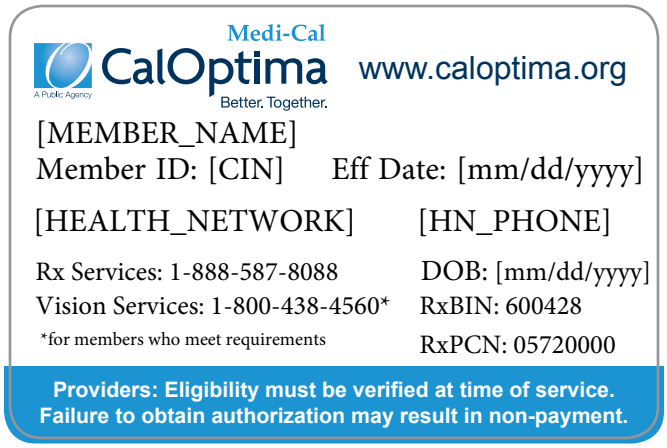
Welcome to CalOptima! CalOptima is the Medi-Cal program for Orange County. CalOptima is responsible for managing your health care benefits.

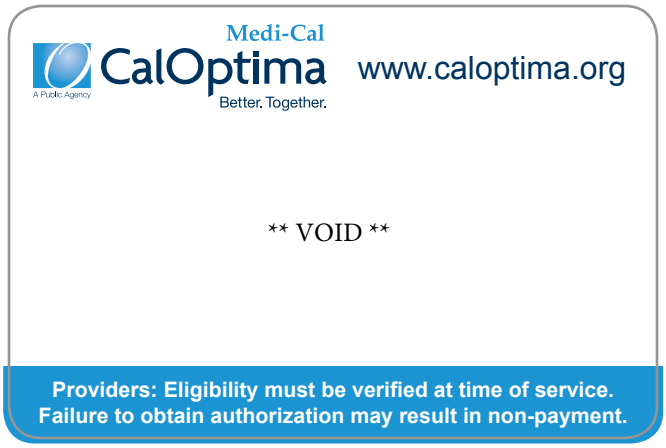
You will receive your Medi-Cal benefits through one of CalOptima's contracted health networks. Please choose a CalOptima health network and a primary care provider (PCP) who is contracted with your health network for each Medi-Cal eligible member of your family. You can choose the same health network for all your family members.

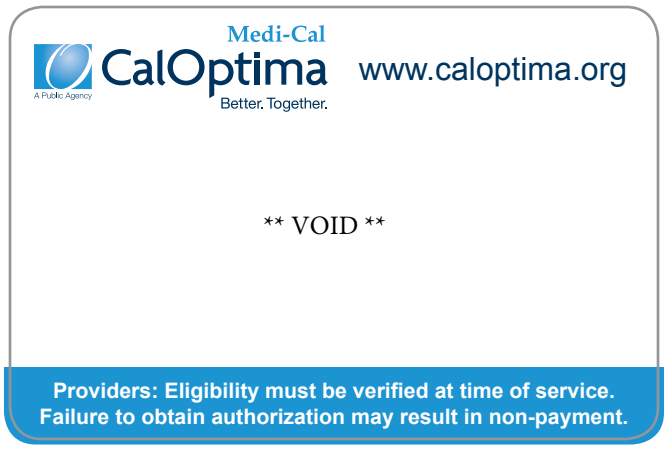
Please use the Health Network Selection Form to choose a health network and PCP for each member of your family. Fill out, sign and return the form to CalOptima as soon as possible. **If you do not choose a health network, CalOptima will choose one for you after 30 days.**

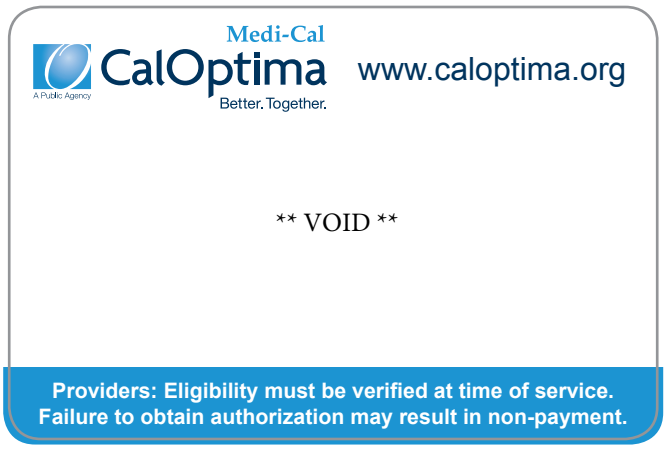
You and your eligible family members may ask to change health networks every 30 days. To do this, you need to complete a Health Network Selection Form. CalOptima has to receive your form by the 10th of the month for your health network change to be effective the 1st of the following month.

If you have questions or need help in choosing a health network, please call CalOptima's Customer Service Department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TTY/TDD users can call **1-800-735-2929**. You can also visit our website at www.caloptima.org.









If you have a life-threatening emergency, call 911 or go to the nearest emergency room. Notify your health network within 24 hours. Emergency services for a true emergency are covered by your health network without prior authorization. Your member handbook has more information on emergency services and how to access your doctor after hours.

For Providers - Member Eligibility Verification:
1-714-246-8540
CalOptima Provider Help Desk:
1-714-246-8600
CalOptima Behavioral Health Line:
1-855-877-3885
TDD/TTY:
1-800-735-2929

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Policy #:	GG.1125
Title:	**Cancer Clinical Trials**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/02
~~Last Review Date:~~	~~08/01/17~~
~~Last~~ Revised Date:	~~08/01/17~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy establishes coverage guidelines for routine health care services provided in connection with a **Member's** participation in a cancer **Clinical Trial**.

II. POLICY

A. CalOptima and its **Health Networks** shall cover routine patient care costs, as defined in Section II.B. of this policy, associated with a **Member's** participation in a Phase I, Phase II, Phase III, or Phase IV cancer **Clinical Trial**, if the **Member** and the cancer **Clinical Trial** meet the requirements set forth herein~~, unless the routine patient care costs are the responsibility of another entity by statute (e.g. California Children's Services (CCS)).~~..

B. Routine patient care costs:

1. Routine patient care costs include health care services that would be:

   a. Provided in the absence of a **Clinical Trial**;

   b. Required for the provision of the investigational drug, item, device, or service;

   c. Required for clinically appropriate monitoring of the cancer treatment;

   d. Provided for the prevention of complications arising from the **Clinical Trial** treatment; or

   e. Needed for reasonable and necessary care arising from complications of the cancer **Clinical Trial**.

2. Routine patient care costs do not include the costs associated with the provision of any of the following:

   a. Drugs or devices that have not been approved by the Federal Drug Administration (FDA) and are associated with the **Clinical Trial**;

   b. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses that a Member may require as a result of treatment being provided for the purposes of the **Clinical Trial**;

   c. Any item or service that is provided solely to satisfy data collection and analysis needs and is not used in the clinical management of the **Member**;

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d. Health care services that, except for the fact that they are being provided in a **Clinical Trial**, are otherwise specifically excluded from coverage under the CalOptima program;

e. Health care services customarily provided by the research sponsors free of charge for any **Member** in the **Clinical Trial**; and

f. Experimental treatment outside of an eligible cancer **Clinical Trial**.

C. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, a **Member** must meet the following requirements:

1. The **Member** must be diagnosed with cancer;

2. The **Member** must be accepted into a Phase I, II, III, or IV **Clinical Trial** for cancer; and

3. The **Member's** treating physician, who is contracted by the **Health Network** to provide health care services, or who participates with CalOptima for a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, must recommend the **Member's** participation in the cancer **Clinical Trial**.

D. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, the cancer **Clinical Trial** must meet the following requirements:

1. The cancer **Clinical Trial** endpoints must not be defined exclusively to test toxicity, or disease pathophysiology, but must have a therapeutic intent;

2. The principal purpose of the cancer **Clinical Trial** is to test whether the intervention potentially improves the **Member's** health outcomes;

3. The cancer **Clinical Trial** is well-supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;

4. The cancer **Clinical Trial** does not unjustifiably duplicate existing studies;

5. The cancer **Clinical Trial** design is appropriate to answer the research question being asked in the **Clinical Trial**;

6. The cancer **Clinical Trial** is sponsored by a credible organization or individual capable of executing the proposed **Clinical Trial** successfully;

7. The cancer **Clinical Trial** is in compliance with Federal regulations relating to the protections of human subjects; and

8. All aspects of the **Clinical Trial** are conducted according to the appropriate standards of scientific integrity.

9. The treatment provided in the cancer **Clinical Trial** must either be:

   a. Approved by one (1) of the following: National Institutes of Health, the FDA, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs; or

   b. Involve a drug that is exempt under federal regulations from a new drug application.

E. CalOptima and its **Health Networks** shall not be prohibited from restricting coverage for routine patient care costs associated with a cancer **Clinical Trial** in California, unless the protocol for the **Clinical Trial** is not provided for at a California hospital or by a California physician.

F. The provision of services as defined under this policy shall not in itself give rise to liability on the part of CalOptima, or the **Health Network**.

G. CalOptima, or a **Health Network**, shall provide care management services to a **Member** who is participating in a cancer **Clinical Trial** to assure that the **Member** is afforded continuity of care, referred to all available resources for his or her illness, and to continue to verify that all eligibility requirements as set forth herein continue to be met.

III. PROCEDURE

A. A Provider~~,~~ or Practitioner~~,~~ shall obtain prior authorization for reimbursement of routine patient care costs related to a **CalOptima Direct** or **CCN Member's** participation in a cancer **Clinical Trial,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

B. A **Provider**, or **Practitioner**, shall obtain prior authorization for reimbursement of routine patient care costs related to a **Health Network Member's** participation in a cancer **Clinical Trial**, in accordance with the policies established by the **Member's Health Network**.

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. DHCS California Children's~~'~~ Services (CCS) Numbered Letter (NL) ~~37-1992~~ 37-1292: Coverage of Experimental and/or Investigational Services
~~C.~~D. CalOptima Health Network Service Agreement
~~D.~~E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~E.~~F. CalOptima Three-Way Agreement with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~F.~~G. Health and Safety Code, §1370.6
~~G.~~H. Medicare National Coverage Determination 100-03, July 9, 2007

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~~H.~~I. Welfare and Institutions Code, §14087.11

VI. REGULATORY AGENCY APPROVALS

A. 02/29/16: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	11/01/2002	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	05/01/2007	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	11/01/2015	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
~~California Children Services (CCS)~~	~~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 (21) years who have CCS Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.~~
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
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.
Clinical Trial	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
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.
Member	An enrollee-beneficiary of a CalOptima program.

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Policy #:	GG.1125
Title:	**Cancer Clinical Trials**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/02
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy establishes coverage guidelines for routine health care services provided in connection with a **Member's** participation in a cancer **Clinical Trial**.

II. POLICY

A. CalOptima and its **Health Networks** shall cover routine patient care costs, as defined in Section II.B. of this policy, associated with a **Member's** participation in a Phase I, Phase II, Phase III, or Phase IV cancer **Clinical Trial**, if the **Member** and the cancer **Clinical Trial** meet the requirements set forth herein..

B. Routine patient care costs:

1. Routine patient care costs include health care services that would be:

   a. Provided in the absence of a **Clinical Trial**;

   b. Required for the provision of the investigational drug, item, device, or service;

   c. Required for clinically appropriate monitoring of the cancer treatment;

   d. Provided for the prevention of complications arising from the **Clinical Trial** treatment; or

   e. Needed for reasonable and necessary care arising from complications of the cancer **Clinical Trial**.

2. Routine patient care costs do not include the costs associated with the provision of any of the following:

   a. Drugs or devices that have not been approved by the Federal Drug Administration (FDA) and are associated with the **Clinical Trial**;

   b. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses that a Member may require as a result of treatment being provided for the purposes of the **Clinical Trial**;

   c. Any item or service that is provided solely to satisfy data collection and analysis needs and is not used in the clinical management of the **Member**;

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d. Health care services that, except for the fact that they are being provided in a **Clinical Trial**, are otherwise specifically excluded from coverage under the CalOptima program;

e. Health care services customarily provided by the research sponsors free of charge for any **Member** in the **Clinical Trial**; and

f. Experimental treatment outside of an eligible cancer **Clinical Trial**.

C. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, a **Member** must meet the following requirements:

1. The **Member** must be diagnosed with cancer;

2. The **Member** must be accepted into a Phase I, II, III, or IV **Clinical Trial** for cancer; and

3. The **Member's** treating physician, who is contracted by the **Health Network** to provide health care services, or who participates with CalOptima for a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, must recommend the **Member's** participation in the cancer **Clinical Trial**.

D. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, the cancer **Clinical Trial** must meet the following requirements:

1. The cancer **Clinical Trial** endpoints must not be defined exclusively to test toxicity, or disease pathophysiology, but must have a therapeutic intent;

2. The principal purpose of the cancer **Clinical Trial** is to test whether the intervention potentially improves the **Member's** health outcomes;

3. The cancer **Clinical Trial** is well-supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;

4. The cancer **Clinical Trial** does not unjustifiably duplicate existing studies;

5. The cancer **Clinical Trial** design is appropriate to answer the research question being asked in the **Clinical Trial**;

6. The cancer **Clinical Trial** is sponsored by a credible organization or individual capable of executing the proposed **Clinical Trial** successfully;

7. The cancer **Clinical Trial** is in compliance with Federal regulations relating to the protections of human subjects; and

8. All aspects of the **Clinical Trial** are conducted according to the appropriate standards of scientific integrity.

9. The treatment provided in the cancer **Clinical Trial** must either be:

a. Approved by one (1) of the following: National Institutes of Health, the FDA, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs; or

b. Involve a drug that is exempt under federal regulations from a new drug application.

E. CalOptima and its **Health Networks** shall not be prohibited from restricting coverage for routine patient care costs associated with a cancer **Clinical Trial** in California, unless the protocol for the **Clinical Trial** is not provided for at a California hospital or by a California physician.

F. The provision of services as defined under this policy shall not in itself give rise to liability on the part of CalOptima, or the **Health Network**.

G. CalOptima, or a **Health Network**, shall provide care management services to a **Member** who is participating in a cancer **Clinical Trial** to assure that the **Member** is afforded continuity of care, referred to all available resources for his or her illness, and to continue to verify that all eligibility requirements as set forth herein continue to be met.

III. PROCEDURE

A. A Provider or Practitioner shall obtain prior authorization for reimbursement of routine patient care costs related to a **CalOptima Direct** or **CCN Member's** participation in a cancer **Clinical Trial,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

B. A **Provider**, or **Practitioner**, shall obtain prior authorization for reimbursement of routine patient care costs related to a **Health Network Member's** participation in a cancer **Clinical Trial**, in accordance with the policies established by the **Member's Health Network**.

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. DHCS California Children's Services (CCS) Numbered Letter (NL) 37-1292: Coverage of Experimental and/or Investigational Services
D. CalOptima Health Network Service Agreement
E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
F. CalOptima Three-Way Agreement with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Health and Safety Code, §1370.6
H. Medicare National Coverage Determination 100-03, July 9, 2007
I. Welfare and Institutions Code, §14087.11

VI. REGULATORY AGENCY APPROVALS

A. 02/29/16: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2002	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	05/01/2007	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	11/01/2015	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
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.
Clinical Trial	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
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.
Member	An enrollee-beneficiary of a CalOptima program.

Policy #:	GG.1515
Title:	**Criteria for Medically Necessary Automobile Orthopedic Positioning Devices**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/1999
~~Last Review Date:~~	~~08/01/17~~
~~Last~~ Revised Date:	~~08/01/17~~04/04/2019

I. PURPOSE

This policy defines the Durable Medical Equipment (DME) guidelines and Medical Necessity criteria for reimbursement of Medically Necessary Automobile Orthopedic Positioning Devices (AOPDs) provided to Members.

II. POLICY

A. An AOPD is a Covered Service under the Whole-Child Model (WCM) program or the CalOptima Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services program when the device meets the criteria and conditions set forth in this policy.

B. Purchase of an AOPD shall require Prior Authorization by CalOptima or the Member's Health Network to be eligible for reimbursement.

C. CalOptima~~,~~ or a Health Network~~,~~ shall provide reimbursement for only one (1) AOPD per Member.

D. A request for reimbursement of an AOPD shall be accompanied by all required documentation.

E. CalOptima~~,~~ or a Health Network~~,~~ shall not authorize the purchase of standard commercially available car seats, vests, or harnesses that are required by California state law for children under six (6) years of age and under sixty (60) pounds.

F. CalOptima~~,~~ or a Health Network~~, shall not~~ will review for Medical Necessity and, if indicated, will authorize the purchase of ~~a Medically Necessary car seat~~an AOPD for children that ~~is otherwise available through the~~are not California ~~Children~~Children's Services ~~Program~~ (CCS~~) or CCS~~)-eligible but require a specially adapted AOPD because of a medical condition under the EPSDT Services program ~~for a Member who is eligible for services through~~.

G. No sooner than the ~~CCS Program~~Department of Health Care Services (DHCS)-approved WCM program effective date, CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for CCS-eligible individuals enrolled in the WCM program, in accordance with CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program.

1. For WCM members, an AOPD shall be evaluated for Medical Necessity in accordance with all current CCS DME Guidelines as provided in CCS Numbered Letters.

III. PROCEDURE

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A. CalOptima and its Health Networks shall utilize the following criteria when determining the Medical Necessity of an AOPD:

1. Car Seats

   a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

   b. Criteria:

      i. The Member shall be over four (4) years of age;

      ii. The Member shall be either over forty (40) pounds, or over forty (40) inches in height; and

      iii. The Member shall meet at least one (1) of the following criteria:

         a) The Member has a moderate to minimal trunk control or sitting ability, moderate to minimal lateral head control, and requires total postural support;

         b) The Member is at risk for breathing complications as a result of poor trunk control or alignment; or

         c) The Member has a skeletal deformity that requires total postural support for safe transportation.

   c. Related Considerations

      i. The Member's height, width, or physical deformity precludes use of a commercially available car seat.

      ii. A harness, or vest, will not provide the Member with enough stability to remain in proper alignment or allow for safe transport.

      iii. The Member cannot be transported in a wheelchair because the family does not own an appropriate vehicle to allow transport in a wheelchair.

2. Harnesses or Vests

   a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

   b. Criteria

      i. The Member shall be over four (4) years of age;

      ii. The Member shall be over forty (40) pounds or over forty (40) inches in height; and

      iii. The Member shall at least one (1) of the following criteria:

         a) The Member has a moderate to minimal trunk control sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment;

c) The Member has a skeletal deformity that requires total postural support for safe transportation; or

d) The Member requires transportation in other than an upright position due to deformity or surgical corrections.

c. Related Considerations

i. The Member's physical deformity or trunk instability precludes use of a standard seat belt or commercially available vest, or harness.

ii. A standard seat belt, or commercially available vest/harness, will not provide the Member with enough stability to remain in proper alignment, or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own appropriate vehicle to allow transport in a wheelchair.

~~B. CalOptima and its Health Networks shall refer medically eligible CCS Members to the CCS program for consideration of AOPD under the EPSDT Service program.~~

~~C.~~B. A request for reimbursement of an AOPD shall be accompanied by:

~~1. A current physician prescription;~~
1. A current prescription provided by the physician of the appropriate specialty for treating the child's condition that the device is intended to address;

a. For children whose CCS-Eligible Condition is the condition necessitating the AOPD, the prescribing physician shall be CCS-paneled.

2. A current medical report that justifies the Medical Necessity of the item requested; and

3. A current physical therapy~~,~~ or occupational therapy, assessment that addresses the criteria as defined in Section III.A. of this policy~~.~~ and includes:

~~D. CalOptima and its Health Networks shall monitor the outcome of CCS referrals for CCS authorization.~~
a. Physical findings;

b. Functional status related to the DME item requested; and

c. A home, school and community accessibility assessment, if indicated.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

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A. California Children's Services Guide for Purchase of Durable Medical Equipment (DME)
B. California Children's Services (CCS) Numbered Letter (NL) 17-1199: Automobile Orthopedic Positioning Devices (AOPDs)
C. California Children's Services (CCS) Numbered Letter (NL) 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
D. California Vehicle Code, §27360
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Policy GG.1101: California Children's Services (CCS) /Whole -Child Model – Coordination with County CCS Program
G. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~98-06~~18-023: California Children Services Whole Child Model Program (supersedes APL 18-011)~~Numbered Letters 01-0298 and 09-0598~~
H. Department of Health Services (DHCS) All Plan Letter (APL) ~~14-017~~18-007: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal ~~Beneficiaries~~Members Under the Age of Twenty-One
I. Title 22, California Code of Regulations (CCR), §§ 51321 and 51160

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	05/01/1999	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	05/01/2007	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	11/01/2015	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	10/01/2016	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	08/01/2017	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	04/04/2019	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal

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IX. GLOSSARY

Term	Definition
Automobile Orthopedic Positioning Devices (AOPDs)	A non-standard positioning device (car sear and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pad that assist in head and truck positioning while being transported in a motor vehicle.
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.
CalOptima	For purposes of this policy, CalOptima shall include both CalOptima Direct and CalOptima Community Network (CCN).
Covered Service	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.
Durable Medical Equipment (DME)	Durable Medical Equipment is any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to an individual in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the patient's home.
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 includes periodic screening that includes at a minimum a comprehensive health and developmental history (including assessment of both physical and mental health development); an unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level taking into account age and risk factors; and health education (including anticipatory guidance), vision, dental, and hearing services. In addition, other necessary health care, diagnostic services, treatment and measures described in Title 42, US Code, Section 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Necessity or Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
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.

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Policy #:	GG.1515
Title:	**Criteria for Medically Necessary Automobile Orthopedic Positioning Devices**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/1999
Revised Date:	04/04/2019

I. PURPOSE

This policy defines the Durable Medical Equipment (DME) guidelines and Medical Necessity criteria for reimbursement of Medically Necessary Automobile Orthopedic Positioning Devices (AOPDs) provided to Members.

II. POLICY

A. An AOPD is a Covered Service under the Whole-Child Model (WCM) program or the CalOptima Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services program when the device meets the criteria and conditions set forth in this policy.

B. Purchase of an AOPD shall require Prior Authorization by CalOptima or the Member's Health Network to be eligible for reimbursement.

C. CalOptima or a Health Network shall provide reimbursement for only one (1) AOPD per Member.

D. A request for reimbursement of an AOPD shall be accompanied by all required documentation.

E. CalOptima or a Health Network shall not authorize the purchase of standard commercially available car seats, vests, or harnesses that are required by California state law for children under six (6) years of age and under sixty (60) pounds.

F. CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for children that are not California Children's Services (CCS)-eligible but require a specially adapted AOPD because of a medical condition under the EPSDT Services program.

G. No sooner than the Department of Health Care Services (DHCS)-approved WCM program effective date, CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for CCS-eligible individuals enrolled in the WCM program, in accordance with CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program.

1. For WCM members, an AOPD shall be evaluated for Medical Necessity in accordance with all current CCS DME Guidelines as provided in CCS Numbered Letters.

III. PROCEDURE

Back to Agenda

A. CalOptima and its Health Networks shall utilize the following criteria when determining the Medical Necessity of an AOPD:

1. Car Seats

a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

b. Criteria:

i. The Member shall be over four (4) years of age;

ii. The Member shall be either over forty (40) pounds, or over forty (40) inches in height; and

iii. The Member shall meet at least one (1) of the following criteria:

a) The Member has a moderate to minimal trunk control or sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment; or

c) The Member has a skeletal deformity that requires total postural support for safe transportation.

c. Related Considerations

i. The Member's height, width, or physical deformity precludes use of a commercially available car seat.

ii. A harness, or vest, will not provide the Member with enough stability to remain in proper alignment or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own an appropriate vehicle to allow transport in a wheelchair.

2. Harnesses or Vests

a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

b. Criteria

i. The Member shall be over four (4) years of age;

ii. The Member shall be over forty (40) pounds or over forty (40) inches in height; and

iii. The Member shall at least one (1) of the following criteria:

a) The Member has a moderate to minimal trunk control sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment;

c) The Member has a skeletal deformity that requires total postural support for safe transportation; or

d) The Member requires transportation in other than an upright position due to deformity or surgical corrections.

c. Related Considerations

i. The Member's physical deformity or trunk instability precludes use of a standard seat belt or commercially available vest, or harness.

ii. A standard seat belt, or commercially available vest/harness, will not provide the Member with enough stability to remain in proper alignment, or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own appropriate vehicle to allow transport in a wheelchair.

B. A request for reimbursement of an AOPD shall be accompanied by:

1. A current prescription provided by the physician of the appropriate specialty for treating the child's condition that the device is intended to address;

a. For children whose CCS-Eligible Condition is the condition necessitating the AOPD, the prescribing physician shall be CCS-paneled.

2. A current medical report that justifies the Medical Necessity of the item requested; and

3. A current physical therapy or occupational therapy, assessment that addresses the criteria as defined in Section III.A. of this policy and includes:

a. Physical findings;

b. Functional status related to the DME item requested; and

c. A home, school and community accessibility assessment, if indicated.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. California Children's Services Guide for Purchase of Durable Medical Equipment (DME)
B. California Children's Services (CCS) Numbered Letter (NL) 17-1199: Automobile Orthopedic Positioning Devices (AOPDs)
C. California Children's Services (CCS) Numbered Letter (NL) 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
D. California Vehicle Code, §27360

E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-023: California Children Services Whole Child Model Program (supersedes APL 18-011)
H. Department of Health Services (DHCS) All Plan Letter (APL) 18-007: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of Twenty-One
I. Title 22, California Code of Regulations (CCR), §§ 51321 and 51160

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/1999	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	05/01/2007	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	11/01/2015	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	10/01/2016	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	08/01/2017	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	04/04/2019	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal

IX. GLOSSARY

Term	Definition
Automobile Orthopedic Positioning Devices (AOPDs)	A non-standard positioning device (car sear and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pad that assist in head and truck positioning while being transported in a motor vehicle.
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.
CalOptima	For purposes of this policy, CalOptima shall include both CalOptima Direct and CalOptima Community Network (CCN).
Covered Service	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.
Durable Medical Equipment (DME)	Durable Medical Equipment is any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to an individual in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the patient's home.
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 includes periodic screening that includes at a minimum a comprehensive health and developmental history (including assessment of both physical and mental health development); an unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level taking into account age and risk factors; and health education (including anticipatory guidance), vision, dental, and hearing services. In addition, other necessary health care, diagnostic services, treatment and measures described in Title 42, US Code, Section 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Necessity or Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
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.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

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Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

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WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

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4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

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

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

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integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

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Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

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While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

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To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

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Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

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Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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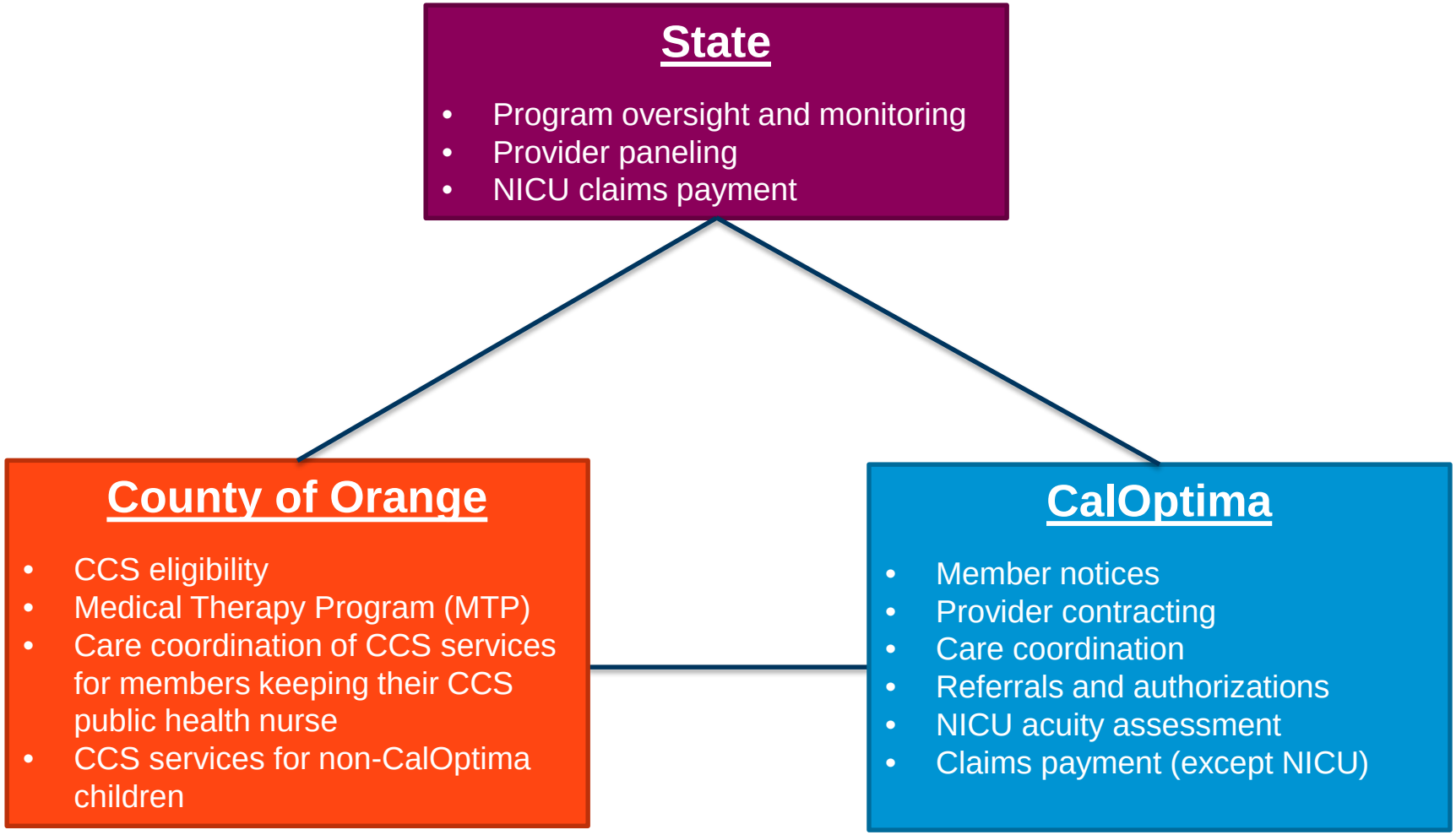
Background

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Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

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Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

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- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

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The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

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Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader — **Authorized Signature**

10/23/2017 — **Date**

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RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

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and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

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The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

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1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

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2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

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1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

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a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

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None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

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IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

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Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

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Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

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3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

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Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES 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. This APL supersedes APL 18-011.

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]

[1] CCS N.L.s can be found at: https://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). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), 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 continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning 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 – Implemented 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	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed 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 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

[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

determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical 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, 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). WCM counties participating with the MTP will continue to receive a separate allocation for this program and are responsible for care coordination of MTP services.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices. Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[6]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/Pediatric Intensive Care Unit/Neonatal Intensive Care Unit (NICU)

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, as well as all 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,

[6] See the WCM CCS N.L. Category List. is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Index-Category-List-June2018.xls

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 serves as the primary vehicle for ensuring 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. The MOU must include, at a minimum, all of the provisions specified in the MOU template and must be consistent with the requirements of SB 586. MCPs are required to submit an executed MOU to DHCS 105 days prior to implementation. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS members 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, including administrative functions, from the county CCS program to the MCPs.[8] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensuring C.O.C. and services for members who are 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 the Children's Medical Services Net (CMS Net) system 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 C.O.C. of already approved service authorization requests, as required by this APL and applicable state and federal laws.

[7] See footnote 5. The MOU template can be found on the CCS WCM website.
[8] See footnote 4. WIC Section 14094.7(d)(4)(C).

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When a CCS-eligible member moves from one county to another, 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 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 must communicate all resolved disputes in writing to the MCP. 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 CCSRedesign@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 must assess each CCS member'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 removes or limits existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

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[9] See footnote 4. WIC Section 14093.06(b).
[10] Unresolved disputes must be referred to: CCSRedesign@dhcs.ca.gov
[11] See footnote 4. WIC Section 14094.15(d).

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 CCS members enrolling in the MCP, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level through:

   - 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 who 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, as described below:

   <u>New Members and Newly CCS-Eligible Members Determined High Risk</u>
   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.

   <u>Risk Assessment</u>
   The risk assessment process must address:

   - 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;

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- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a 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 identify 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 to be 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, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- 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.

[12] See footnote 4. WIC Section 14094.11(b)(4).

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The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must 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 must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- 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; and
- 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 members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of 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 members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

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 members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a 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 a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[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 must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to 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:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] 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 C.O.C. 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 member's 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 who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

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 member. The MCPs must provide care coordination to 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.

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[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 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. 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 DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- 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. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. 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 an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with 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. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their 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.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

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D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS 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

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] 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 the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. 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. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

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

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

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centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] 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.[34]

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 FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet 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: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

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IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] 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.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] 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
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. 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:[41]

- 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; and
- Procedures to detect both under- and over-utilization of health care services.

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 format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. 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 companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] 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

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. 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 the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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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

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redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

[8] See WIC Section 14094.7(d)(4)(C), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&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.

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[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&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;

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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.

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[24] See APL 17-006, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf
[25] See APL 17-006
[26] See CCS N.L. 03-0810, which is available at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[27] APL 17-010 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf

F. Out-of-Network Access

MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.[28] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[29] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[30]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS fee-for-service rates, unless the provider and the MCP enter into

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[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

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CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-Out: Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity	MCP	MCP	DHCS

IV. MCP Responsibilities to DHCS

A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

approval status.[34] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[38]

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

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[34] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Approval of Modifications to CalOptima's Policy and Procedure Related to CalOptima's Whole-Child Model Program

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to modify existing Policy and Procedure in connection with Whole-Child Model program as follows:

A. GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs [Medi-Cal, OneCare, OneCare Connect].

Background and Discussion

The California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children under age 21 who meet eligibility criteria based on financial and medical conditions. Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal Managed Care Plan (MCP) contracts for County Organized Health Systems (COHS) on a phased-in basis.

On November 9, 2018, DHCS delayed the implementation of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS determined that more time is needed to ensure effective preparation and a robust number of CCS-paneled providers. Additionally, on December 23, 2018, DHCS released All Plan Letter (APL) 18-023 California Children's Services Whole-Child Model, which superseded the APL originally published on June 28, 2018, and included clarifying language and new guidance regarding Neonatal Intensive Care Unit (NICU), High Risk Infant Follow-up (HRIF) program, pediatric palliative care, and continuity of care appeals.

Below is additional information regarding the modified policy which includes revisions related to WCM as well as clarification related to existing operations:

A. GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs outlines the criteria and process for coverage of durable medical equipment (DME) for a member, excluding wheelchair rental, purchase, and repairs. CalOptima revised this policy pursuant to the CalOptima review process to ensure alignment with current operations to include continuity of care with a specialized or customized DME provider for up to 12 months in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. This policy is in alignment with the California Children's Services Whole Child Model program requirements.

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Additional policies are expected to be submitted for Board approval at a later time.

Fiscal Impact
Management will include all projected revenues and expenses associated with the WCM program in the Fiscal Year 2019-20 Operating Budget. Therefore, the fiscal impact of the recommended action to modify CalOptima Policy GG.1502 is a budgeted item and is not expected to have an additional fiscal impact in the current year.

Rationale for Recommendation
To ensure CalOptima meets all requirements of the Whole-Child Model program, approval of the requested action is recommended.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs [Medi-Cal, OneCare, OneCare Connect]
2. GG.1325: Continuity of Care for Members Transitioning into CalOptima Service [Medi-Cal]
3. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program

/s/ Michael Schrader — *4/24/2019*
Authorized Signature — **Date**

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Policy #:	GG.1502
Title:	**Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2000
~~Last Review Date:~~	~~08/01/17~~
~~Last~~ Revised Date:	05/02/2019~~08/01/17~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria and process for coverage of **Durable Medical Equipment (DME)** for a **Member**, excluding wheelchair rental, purchase, and repairs.

II. POLICY

A. CalOptima or a **Health Network** shall provide **DME** 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, **DME** prescribed for a **Member** may be a **Covered Service** when it is **Medically Necessary** to:

1. Preserve bodily functions essential to **Activities of Daily Living (ADL)** or to prevent significant physical disability; or

2. Improve the medical status or functional ability of a **Member** 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)**, in accordance with CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices;

2. Alterations or improvements to real property, except when authorized for home dialysis services;

3. Books or other items of a primarily educational nature;

4. Air conditioners, air filters or heaters;

5. Food blenders;

6. Reading lamps or other lighting devices;

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7. Bicycles, tricycles, or exercise equipment, except as otherwise permitted in this Ppolicy;

8. Television sets;

9. Orthopedic mattresses, recliners, rockers, seat lift chairs (for Medi-Cal only), or other furniture items;

10. Waterbeds;

11. Household items;

12. Items required solely for, educational, or vocational needs; and

13. 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 not grant an authorization for **DME**, if a household or furniture item will adequately serve the **Member's** medical needs.

E. CalOptima or a **Health Network** shall limit authorization for **DME** to the lowest cost item that meets a **Member's** medical needs.

F. If a **Member** has a speech, language or hearing disorder, CalOptima, or a **Health Network**, shall authorize an Augmentation and Alternative Communication Device (AAC) for the **Member** when the following conditions are met:

1. A licensed speech and language pathologist conducts an assessment of the **Member's** medical need for AAC.

2. A physical or occupational therapist conducts an assessment of the **Member's** medical need for AAC if the **Member** has physical limitations which may impact his or her ability to use the AAC.

G. CalOptima or a **Health Network** will provide **Continuity of Care** 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.

~~G.~~H. CalOptima or a **Health Network** may authorize the following **DME** for a **Member** who is an inpatient in a **Skilled Nursing Facility (SNF)** or **Intermediate Care Facility (ICF)**:

1. Equipment that is necessary for the continuous care and unusual medical needs of the **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.

2. Canes, crutches, wheelchair cushions, and walkers that are custom made or modified to meet the unusual medical needs of the **Member** and the need is expected to be permanent.

3. Suction and position pressure apparatuses that a **Member** will continuously use or must be immediately available to the **Member** for one (1) month or more.

~~H.~~I. CalOptima or a **Health Network** shall authorize **DME** for a **Member**, in accordance with the following provisions:

1. A **Practitioner** shall obtain prior authorization for the following:

   a. Purchase of **DME** when the ~~cumulative~~total cost of items purchased within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month;

   b. Repair or maintenance of **DME** when the ~~cumulative~~total cost of the repair and maintenance of items within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month. The cost of repairs shall not exceed the replacement value of the item being repaired;

   c. Rental of **DME** when the ~~cumulative~~total cost of renting items within a **DME** category group exceeds five hundred dollars ($500) within a fifteen (15) month period. This includes any daily amount that an individual item, or combination of a similar group of items, exceeds the five hundred dollar ($500) threshold. The fifteen (15) month period begins on the date the first item is rented;

   ~~d. Provision of oxygen when more than the equivalent of two (2) H tanks are provided during one (1) calendar month; and~~

   d. Rental or purchase of an oxygen delivery system;

   e. Purchase, rental, repair, or maintenance of any unlisted devices or equipment, regardless of the dollar amount for any individual item or the ~~cumulative~~total cost.

2. CalOptima or a **Health Network** may audit **DME** authorization requests for appropriateness and accuracy, as necessary.

~~I.~~J. A **Member** is responsible for the appropriate use and care of **DME** purchased for the **Member's** benefit.

~~J.~~K. A **DME** provider shall ensure that the **DME** provided to a **Member** is appropriate for the **Member's** medical needs. A **DME** provider shall, at no cost to CalOptima, or a **Health Network**, adjust, modify, or replace the **DME**, as necessary, when the **DME** provided does not:

1. Meet the **Member's** medical needs and the **Member's** medical condition has not changed since the date the **DME** was originally provided; or

2. Meet the **Member's** functional needs when in actual use.

K. CalOptima or a **Health Network** shall consider **DME** to be purchased when previously paid rental charges equal the maximum allowable purchase price of the rented **DME**. CalOptima, or the **Health Network**, shall provide no further reimbursement to the **DME** provider for the use of such **DME**, unless payment is for the subsequent repair and maintenance of the **DME**, as authorized by CalOptima, or the **Health Network**.

L. Effective no sooner than July 1, 2019, CalOptima or a **Health Network** shall be responsible for authorization and claims processing for the rental, purchase and repair of **Specialized or Customized DME** for Whole Child Model (WCM) **Members** whose custom **DME** is **Medically Necessary** to treat or ameliorate the effects of their **California Children's Services (CCS)-eligible Condition**. **Specialized or Customized DME** may include, but is not limited, to devices to assist

in standing, ambulating, or positioning parts of the body to improve or maintain function, or to prevent the development of conditions that may result from inadequate support or positioning of the individual's anatomy.

M. With respect to the WCM program, CalOptima and the **Health Networks** shall ensure compliance with all current and applicable:

1. State and federal laws and regulations, as well as contractual requirements;

2. California Department of Health Care Services (DHCS) guidance, including All Plan Letter 18-023: California Children's Services Whole Child Model;

3. CCS programs guidelines, including CCS program regulations, regulations related to WCM program. CCS Numbered Letters, and CCS program information notices, in developing criteria for use by their respective chief medical officer or the equivalent and any other care management staff.

a. When applicable CCS clinical guidelines to not exist, CalOptima and the **Health Networks** shall use evidence-based guidelines or treatment protocols that are medically appropriate given the **Member's CCS-eligible condition**.

b. Any CCS Numbered Letters that fall within the Index Category of Authorizations/Benefits, as identified by DHCS, are applicable to CalOptima and the **Health Networks**. For these applicable CCS Numbered Letters, including those referenced in Section V. of this Policy, CalOptima and the **Health Network** shall assume the role of the county or state CCS program as described in the CCS Numbered Letters.

III. PROCEDURE

A. A **Practitioner** shall identify a **Member** who has a **Medical Necessity** for **DME** and issue a written prescription to the **Member** for the purchase, rental, repair, or maintenance of the **DME**. Such prescription shall include:

1. Full name, address, telephone number, and signature of the prescribing **PCP**, or **Provider**;

2. Date of prescription;

3. Specific item(s) prescribed;

4. Estimated length of time the **DME** is determined to be **Medically Necessary**; and

5. **Member's** medical condition or diagnosis necessitating the **DME**, including:

a. **Member's** medical status and functional limitation(s); and

b. Description of how the requested **DME** 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. A **Practitioner** shall obtain authorization to provide **DME** to a **Member** by submitting a request form with a copy of the signed and dated prescription to the CalOptima Utilization Management (UM) Department, or a **Health Network**.

1. For a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, the **Practitioner** shall submit a CalOptima Authorization Request Form (ARF), in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

2. For a **Health Network Member**, the **Practitioner** shall follow the **Health Network's** authorization procedures.

3. A **Practitioner** shall include the following information, at a minimum, in the authorization request for **DME** submitted to CalOptima, or a **Health Network**:

    a. Date of request;

    b. **Member's** name, appropriate health care identification, or, and address;

    c. Medical justification for the requested **DME**;

    d. Description of the **DME**, including:

        i. Manufacturer name, model type or serial number, and purchase price;

        ii. Product description;

        iii. Monthly rental charge, if applicable, and whether it may be applied toward the purchase of the **DME**;

        iv. Billing and procedure codes; and

        v. Estimated length of need, whether rental or purchase is requested, and associated charges.

    e. **DME Provider's** name, address, telephone number, contact name and telephone number, and National Provider Identification (NPI) number; and

    f. Copy of prescription containing the information required as set forth in Section III.A. of this Policy.

4. For unlisted **DME** requests, a **Provider** shall provide the documentation as set forth in Section III.B.3. of this Policy and copies of catalog pages and medical justification to substantiate the reason(s) a listed item is insufficient to meet the **Member's** medical needs.

C. CalOptima or a **Health Network** shall review the authorization request submitted by a **Member's Provider**. If the authorization request is incomplete, CalOptima, or a **Health Network**, shall require the **PCP**, or **Provider**, to provide additional information.

D. A **Member** may appeal a CalOptima or **Health Network** decision to a requested service in accordance with CalOptima Policies GG.1510: Appeal Process for Decisions Regarding Care and Services, MA.9003: Standard Service Appeal, and CMC.9003: Standard Appeal.

E. Medical Therapy Program - California Children's Services (CCS)/Whole Child Model Program (WCM) **Members**:

1. Effective no sooner than July 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 **Specialized or Customized DME** and **Specialized or Customized DME** repairs with a total cost of over five hundred dollars ($500) to CalOptima. The request will include:

    a. Completed Custom DME Authorization Referral Form;

    b. Signed prescription/provider order for the requested **Specialized or Customized DME**;

        i. The provider order must be prescribed by a CCS-paneled physician who is approved to treat the child's **CCS eligible medical condition**, and who has examined the child within six (6) months.

        ii. If the recommending or prescribing physician is not a CCS-paneled physician approved to treat the child's **CCS eligible medical condition**, the request shall be reviewed by the CCS-approved paneled physician for concurrence prior to submission for authorization; and

    c. Vendor specifications that have been reviewed/confirmed by Medical Therapy Unit (MTU) therapist/supervisor.

2. CalOptima will review and triage these requests to CalOptima Utilization Management/Prior Authorization Department or the **Health Network** staff via secure communication for review and processing.

3. If a referral for **Specialized or Customized DME** or **Specialized or Customized DME** 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 **Specialized or Customized DME** or **Specialized or Customized DME** 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 **Specialized or Customized DME** or **Specialized or Customized DME** repairs that are covered and recommended by the MTU and are in accordance with the current and applicable CCS numbered letter, CalOptima or a **Health Network** will approve the 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 Specialized or Customized DME Provider within standard prior authorization turn around-time requirements for Specialized or Customized DME requests.

F. Effective July 1, 2019, for CCS-eligible Members who are not eligible with Orange County CCS MTP, **Specialized or Customized DME**-related requests will be processed by the **Member's Health Network** consistent with evidence-based medical necessity guidelines and current, applicable CCS numbered letters that define **medical necessity** criteria, except with regard to **Continuity of Care** as described in Section III.F. of this Policy

G. CalOptima or a **Health Network** shall provide **Continuity of Care** for a **Member** eligible with the CCS Program and transitioned into the WCM program with a **Specialized or Customized 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 when deemed **Medically Necessary** by the treating provider.

IV. ATTACHMENT(S)

A. CalOptima Authorization Request Form (ARF)
B. ~~Medicare Physician Certification~~Certificate of Medical Necessity for All Durable Medical Equipment, Except Wheelchairs and Scooters

V. REFERENCES

A. CalOptima Contract for DME Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima Health Network Service Agreement
F. CalOptima Policy CMC.9003: Standard Appeal
~~F.~~G. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~G.~~H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services
J. CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices
~~H.~~K. CalOptima Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
L. CalOptima Policy MA.9003: Standard Appeal
M. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
~~I.~~O. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
P. CCS Numbered Letter 01-0111: Authorization of Insulin Infusion Pumps
Q. CCS Numbered Letter 02-0102: Pulse Oximeters
R. CCS Numbered Letter 02-0107: Authorization of Rental of Portable Home Ventilators Purpose
S. CCS Numbered Letter 02-0197: Authorization of Flutter Valves and ThAIRapy Vests
T. CCS Numbered Letter 09-0514: Powered Mobility Devices
U. CCS Numbered Letter 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
V. CCS Numbered Letter 10-0707: Revised Guidelines for Authorization of Oxygen, Oxygen Delivery Equipment, and Related Supplies
W. CCS Numbered Letter 14-0801: Synthesized Speech Augmentative Communication (SSAC) Devices (Formerly Known as Augmentative/Alternative Communication (AAC) Devices
X. CCS Numbered Letter 18-0605: Nationwide Recall of Vail Enclosed Bed Systems
Y. Department of Health Care Services All Plan Letter 18-023: California Children's Services Whole Child Model Program
~~J.~~Z. Department of Health Care Services Medi-Cal Allied Health Provider Manual Durable Medical Equipment (DME): An Overview
~~K.~~AA. Title 22, California Code of Regulations (C.C.R), §§51303, 51104, 51160, and 51321

~~L.~~BB. Title 42, Code of Federal Regulations (C.F.R), §414.202

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	01/01/2000	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	03/01/2012	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	11/01/2015	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	05/02/2019	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.
Augmentation and Alternative Communication Device (AAC)	A set of tools and strategies that a Member uses to solve everyday communicative challenges, including but not limited to, speech, a shared glance, text, gestures, facial expressions, touch, sign language, symbols, pictures and speech-generating devices.
Automobile Orthopedic Positioning Device (AOPD)	A non-standard positioning device (car seat and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pads that assist in head and trunk positioning while being transported in a motor vehicle.
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.
CalOptima	For purposes of this policy, CalOptima means CalOptima Direct and CalOptima Community Network (CCN).
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.

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 for Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services and Centers for Medicare & Medicaid Services (CMS).
Disability	A physical or mental condition that limits a person's movements, senses, or activities.
Durable Medical Equipment	Any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to a Member in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the Member's home.
Health Network	For purposes of this policy, a Health Network is 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.
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.
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, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
Provider	A physician, 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.
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.

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Policy #:	GG.1502
Title:	**Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2000
Revised Date:	05/02/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria and process for coverage of **Durable Medical Equipment (DME)** for a **Member**, excluding wheelchair rental, purchase, and repairs.

II. POLICY

A. CalOptima or a **Health Network** shall provide **DME** 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, **DME** prescribed for a **Member** may be a **Covered Service** when it is **Medically Necessary** to:

1. Preserve bodily functions essential to **Activities of Daily Living (ADL)** or to prevent significant physical disability; or

2. Improve the medical status or functional ability of a **Member** 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)**, in accordance with CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices;

2. Alterations or improvements to real property, except when authorized for home dialysis services;

3. Books or other items of a primarily educational nature;

4. Air conditioners, air filters or heaters;

5. Food blenders;

6. Reading lamps or other lighting devices;

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7. Bicycles, tricycles, or exercise equipment, except as otherwise permitted in this Policy;

8. Television sets;

9. Orthopedic mattresses, recliners, rockers, seat lift chairs (for Medi-Cal only), or other furniture items;

10. Waterbeds;

11. Household items;

12. Items required solely for, educational, or vocational needs; and

13. 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 not grant an authorization for **DME**, if a household or furniture item will adequately serve the **Member's** medical needs.

E. CalOptima or a **Health Network** shall limit authorization for **DME** to the lowest cost item that meets a **Member's** medical needs.

F. If a **Member** has a speech, language or hearing disorder, CalOptima, or a **Health Network**, shall authorize an Augmentation and Alternative Communication Device (AAC) for the **Member** when the following conditions are met:

1. A licensed speech and language pathologist conducts an assessment of the **Member's** medical need for AAC.

2. A physical or occupational therapist conducts an assessment of the **Member's** medical need for AAC if the **Member** has physical limitations which may impact his or her ability to use the AAC.

G. CalOptima or a **Health Network** will provide **Continuity of Care** 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.

H. CalOptima or a **Health Network** may authorize the following **DME** for a **Member** who is an inpatient in a **Skilled Nursing Facility (SNF)** or **Intermediate Care Facility (ICF)**:

1. Equipment that is necessary for the continuous care and unusual medical needs of the **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.

2. Canes, crutches, wheelchair cushions, and walkers that are custom made or modified to meet the unusual medical needs of the **Member** and the need is expected to be permanent.

3. Suction and position pressure apparatuses that a **Member** will continuously use or must be immediately available to the **Member** for one (1) month or more.

I. CalOptima or a **Health Network** shall authorize **DME** for a **Member**, in accordance with the following provisions:

1. A **Practitioner** shall obtain prior authorization for the following:

   a. Purchase of **DME** when the total cost of items purchased within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month;

   b. Repair or maintenance of **DME** when the total cost of the repair and maintenance of items within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month. The cost of repairs shall not exceed the replacement value of the item being repaired;

   c. Rental of **DME** when the total cost of renting items within a **DME** category group exceeds five hundred dollars ($500) within a fifteen (15) month period. This includes any daily amount that an individual item, or combination of a similar group of items, exceeds the five hundred dollar ($500) threshold. The fifteen (15) month period begins on the date the first item is rented;

   d. Rental or purchase of an oxygen delivery system;

   e. Purchase, rental, repair, or maintenance of any unlisted devices or equipment, regardless of the dollar amount for any individual item or the total cost.

2. CalOptima or a **Health Network** may audit **DME** authorization requests for appropriateness and accuracy, as necessary.

J. A **Member** is responsible for the appropriate use and care of **DME** purchased for the **Member's** benefit.

K. A **DME** provider shall ensure that the **DME** provided to a **Member** is appropriate for the **Member's** medical needs. A **DME** provider shall, at no cost to CalOptima, or a **Health Network**, adjust, modify, or replace the **DME**, as necessary, when the **DME** provided does not:

1. Meet the **Member's** medical needs and the **Member's** medical condition has not changed since the date the **DME** was originally provided; or

2. Meet the **Member's** functional needs when in actual use.

K. CalOptima or a **Health Network** shall consider **DME** to be purchased when previously paid rental charges equal the maximum allowable purchase price of the rented **DME**. CalOptima, or the **Health Network**, shall provide no further reimbursement to the **DME** provider for the use of such **DME**, unless payment is for the subsequent repair and maintenance of the **DME**, as authorized by CalOptima, or the **Health Network**.

L. Effective no sooner than July 1, 2019, CalOptima or a **Health Network** shall be responsible for authorization and claims processing for the rental, purchase and repair of **Specialized or Customized DME** for Whole Child Model (WCM) **Members** whose custom **DME** is **Medically Necessary** to treat or ameliorate the effects of their **California Children's Services (CCS)-eligible Condition**. **Specialized or Customized DME** may include, but is not limited, to devices to assist in standing, ambulating, or positioning parts of the body to improve or maintain function, or to prevent the development of conditions that may result from inadequate support or positioning of the individual's anatomy.

M. With respect to the WCM program, CalOptima and the **Health Networks** shall ensure compliance with all current and applicable:

1. State and federal laws and regulations, as well as contractual requirements;

2. California Department of Health Care Services (DHCS) guidance, including All Plan Letter 18-023: California Children's Services Whole Child Model;

3. CCS programs guidelines, including CCS program regulations, regulations related to WCM program. CCS Numbered Letters, and CCS program information notices, in developing criteria for use by their respective chief medical officer or the equivalent and any other care management staff.

    a. When applicable CCS clinical guidelines to not exist, CalOptima and the **Health Networks** shall use evidence-based guidelines or treatment protocols that are medically appropriate given the **Member's CCS-eligible condition**.

    b. Any CCS Numbered Letters that fall within the Index Category of Authorizations/Benefits, as identified by DHCS, are applicable to CalOptima and the **Health Networks**. For these applicable CCS Numbered Letters, including those referenced in Section V. of this Policy, CalOptima and the **Health Network** shall assume the role of the county or state CCS program as described in the CCS Numbered Letters.

III. PROCEDURE

A. A **Practitioner** shall identify a **Member** who has a **Medical Necessity** for **DME** and issue a written prescription to the **Member** for the purchase, rental, repair, or maintenance of the **DME**. Such prescription shall include:

1. Full name, address, telephone number, and signature of the prescribing **PCP**, or **Provider**;

2. Date of prescription;

3. Specific item(s) prescribed;

4. Estimated length of time the **DME** is determined to be **Medically Necessary**; and

5. **Member's** medical condition or diagnosis necessitating the **DME**, including:

    a. **Member's** medical status and functional limitation(s); and

    b. Description of how the requested **DME** 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. A **Practitioner** shall obtain authorization to provide **DME** to a **Member** by submitting a request form with a copy of the signed and dated prescription to the CalOptima Utilization Management (UM) Department, or a **Health Network**.

1. For a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, the **Practitioner** shall submit a CalOptima Authorization Request Form (ARF), in accordance with

CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

2. For a **Health Network Member**, the **Practitioner** shall follow the **Health Network's** authorization procedures.

3. A **Practitioner** shall include the following information, at a minimum, in the authorization request for **DME** submitted to CalOptima, or a **Health Network**:

   a. Date of request;

   b. **Member's** name, appropriate health care identification, or, and address;

   c. Medical justification for the requested **DME**;

   d. Description of the **DME**, including:

      i. Manufacturer name, model type or serial number, and purchase price;

      ii. Product description;

      iii. Monthly rental charge, if applicable, and whether it may be applied toward the purchase of the **DME**;

      iv. Billing and procedure codes; and

      v. Estimated length of need, whether rental or purchase is requested, and associated charges.

   e. **DME Provider's** name, address, telephone number, contact name and telephone number, and National Provider Identification (NPI) number; and

   f. Copy of prescription containing the information required as set forth in Section III.A. of this Policy.

4. For unlisted **DME** requests, a **Provider** shall provide the documentation as set forth in Section III.B.3. of this Policy and copies of catalog pages and medical justification to substantiate the reason(s) a listed item is insufficient to meet the **Member's** medical needs.

C. CalOptima or a **Health Network** shall review the authorization request submitted by a **Member's Provider**. If the authorization request is incomplete, CalOptima, or a **Health Network**, shall require the **PCP**, or **Provider**, to provide additional information.

D. A **Member** may appeal a CalOptima or **Health Network** decision to a requested service in accordance with CalOptima Policies GG.1510: Appeal Process for Decisions Regarding Care and Services, MA.9003: Standard Service Appeal, and CMC.9003: Standard Appeal.

E. Medical Therapy Program - California Children's Services (CCS)/Whole Child Model Program (WCM) **Members**:

1. Effective no sooner than July 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 **Specialized or Customized DME** and **Specialized or Customized DME**

repairs with a total cost of over five hundred dollars ($500) to CalOptima. The request will include:

a. Completed Custom DME Authorization Referral Form;

b. Signed prescription/provider order for the requested **Specialized or Customized DME**;

i. The provider order must be prescribed by a CCS-paneled physician who is approved to treat the child's **CCS eligible medical condition**, and who has examined the child within six (6) months.

ii. If the recommending or prescribing physician is not a CCS-paneled physician approved to treat the child's **CCS eligible medical condition**, the request shall be reviewed by the CCS-approved paneled physician for concurrence prior to submission for authorization; and

c. Vendor specifications that have been reviewed/confirmed by Medical Therapy Unit (MTU) therapist/supervisor.

2. CalOptima will review and triage these requests to CalOptima Utilization Management/Prior Authorization Department or the **Health Network** staff via secure communication for review and processing.

3. If a referral for **Specialized or Customized DME** or **Specialized or Customized DME** 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 **Specialized or Customized DME** or **Specialized or Customized DME** 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 **Specialized or Customized DME** or **Specialized or Customized DME** repairs that are covered and recommended by the MTU and are in accordance with the current and applicable CCS numbered letter, CalOptima or a **Health Network** will approve the 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 Specialized or Customized DME Provider within standard prior authorization turn around-time requirements for Specialized or Customized DME requests.

F. Effective July 1, 2019, for CCS-eligible Members who are not eligible with Orange County CCS MTP, **Specialized or Customized DME**-related requests will be processed by the **Member's Health Network** consistent with evidence-based medical necessity guidelines and current, applicable CCS numbered letters that define **medical necessity** criteria, except with regard to **Continuity of Care** as described in Section III.F. of this Policy

G. CalOptima or a **Health Network** shall provide **Continuity of Care** for a **Member** eligible with the CCS Program and transitioned into the WCM program with a **Specialized or Customized 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 when deemed **Medically Necessary** by the treating provider.

IV. ATTACHMENT(S)

A. CalOptima Authorization Request Form (ARF)
B. Certificate of Medical Necessity for All Durable Medical Equipment, Except Wheelchairs and Scooters

V. REFERENCES

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B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
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Q. CCS Numbered Letter 02-0102: Pulse Oximeters
R. CCS Numbered Letter 02-0107: Authorization of Rental of Portable Home Ventilators Purpose
S. CCS Numbered Letter 02-0197: Authorization of Flutter Valves and ThAIRapy Vests
T. CCS Numbered Letter 09-0514: Powered Mobility Devices
U. CCS Numbered Letter 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
V. CCS Numbered Letter 10-0707: Revised Guidelines for Authorization of Oxygen, Oxygen Delivery Equipment, and Related Supplies
W. CCS Numbered Letter 14-0801: Synthesized Speech Augmentative Communication (SSAC) Devices (Formerly Known as Augmentative/Alternative Communication (AAC) Devices
X. CCS Numbered Letter 18-0605: Nationwide Recall of Vail Enclosed Bed Systems
Y. Department of Health Care Services All Plan Letter 18-023: California Children's Services Whole Child Model Program
Z. Department of Health Care Services Medi-Cal Allied Health Provider Manual Durable Medical Equipment (DME): An Overview
AA. Title 22, California Code of Regulations (C.C.R), §§51303, 51104, 51160, and 51321
BB. Title 42, Code of Federal Regulations (C.F.R), §414.202

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2000	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	03/01/2012	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	11/01/2015	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	05/02/2019	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.
Augmentation and Alternative Communication Device (AAC)	A set of tools and strategies that a Member uses to solve everyday communicative challenges, including but not limited to, speech, a shared glance, text, gestures, facial expressions, touch, sign language, symbols, pictures and speech-generating devices.
Automobile Orthopedic Positioning Device (AOPD)	A non-standard positioning device (car seat and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pads that assist in head and trunk positioning while being transported in a motor vehicle.
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.
CalOptima	For purposes of this policy, CalOptima means CalOptima Direct and CalOptima Community Network (CCN).
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.

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 for Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services and Centers for Medicare & Medicaid Services (CMS).
Disability	A physical or mental condition that limits a person's movements, senses, or activities.
Durable Medical Equipment	Any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to a Member in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the Member's home.
Health Network	For purposes of this policy, a Health Network is 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.
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.
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, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
Provider	A physician, 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.
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.

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CalOptima
Better Together

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: _____ (Last) _____ (First) ☐ M ☐ F D.O.B. _____ Age: _____

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

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CERTIFICATE OF MEDICAL NECESSITY
FOR ALL DURABLE MEDICAL EQUIPMENT (DME)
(EXCEPT WHEELCHAIRS AND SCOOTERS)

The provider must complete all applicable areas not completed by the clinician or therapist.

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for Durable Medical Equipment. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information will result in a deferral, denial or delay in payment of the claim.

REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

SECTION 1—Clinician's Information:

Clinician Name *(Print)* Last	First	Phone Number ( )	License Number

Address Street	City	State	ZIP

Clinician's description of the patient's current functional status and need for the requested equipment: _____

SECTION 2—Patient's Information: New Rx *(For Rx Renewal, please also complete 2A below)*

Patient Name *(Print)* Last	First	Phone Number ( )	Date of Birth mm / dd / yy	Medi-Cal Number

Address Street	City	State	ZIP

Date of last face-to-face visit with the beneficiary: _____

Is this beneficiary expected to be institutionalized within the next 10 months? Yes ❒ ❒No Explain ''Yes'' answer: _____

Equipment required for:

❒ Less than 10 months *(code the TAR for a rental)*

❒ More than 10 months *(code the TAR for a purchase)*

SECTION 2A—For Renewal:

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

SECTION 3—Equipment Requested:

a) _____

b) STANDARD: _____ BARIATRIC: _____

c) Replacing existing equiment? Yes ❒ ❒No If yes, explain why: _____

d) Attach repair estimate if replacement with similar equipment is requested.

e) Other DME the beneficiary has: _____

f) How many hours per day of usage? _____

g) Accessories requested and why: _____

h) Custom features requested and why: _____

i) Other equipment currently in the home: Cane ❒ Walker ❒ Crutches ❒ Prosthesis ❒ Manual Wheelchair ❒

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Patient currently using the following equipment: _____

k) When/How often: _____

State specific reason for accessories requested: _____

_____

Power Wheelchair ❒ Hospital Bed ❒ Oxygen ❒ POV (scooter) ❒ Other: j)

l)

DHCS 6181 (08/09)

SECTION 4—Diagnosis Information

Diagnoses: Date of onset:

Prognosis: _____ _____

_____

SECTION 5—Pertinent History:

_____

_____

SECTION 6—Functional Status:

Beneficiary's height: _____ Beneficiary's weight: _____

a) Ambulation: Independent ❒ Walker/Cane ❒ Assisted ❒ Unassisted❒ Unable ❒ Bed confined ❒

Recent fall(s) ❒ Dizziness/Vertigo ❒ Incoordination❒ Ataxia ❒ Severe shortness of breath ❒

b) Transfer: Self ❒ Self, but with great dificulty ❒ Self with a transfer device ❒

Stand by assistant ❒ With assistance ❒ Mechanical or person lift ❒

c) Pertinent physical findings: Edema (location):

Pressure sore(s), state and location: Amputee ❒ Cast ❒ Ataxia ❒

Paralysis/weakness (location): _____ Sitting Posture/Deformity: _____

Cognitive status: _____ Vision: Impaired ❒ Normal ❒

Contractures:

SECTION 7—Living Environment:

House/condominium ❒ Apartment ❒ Stairs ❒ Elevator ❒ Ramp ❒ Hills ❒ SNF ❒ ICF/DD ❒ B&C ❒

Other:

_____

Living Assistance: Lives alone ❒ With other person(s) ❒ Alone most of the day ❒ Alone at night ❒ Attendant care:

Live in attendant ❒ or _____ Hours/day Homemaker ❒ Hours _____

Transportation:

SECTION 8—Hospital Bed:

Document that this beneficiary requires positioning not feasible in an ordinary bed:

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Is frequent repositioning required throughout the day? Yes ❒ ❒No

Is frequent repositioning required throughout the night? Yes ❒ ❒No

Can the beneficiary or caretaker use a ‘‘manual’’ bed? Yes ❒ ❒No

If no, explain why: _____

For any anti-decubitus bed, please attach to the TAR, photos and explanation of previous therapies attempted, the nutritional status, and the latest hemoglobin and hematocrit of the beneficiary.

SECTION 9—DME provider/Therapist attestation and signature/date:

By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.

Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print):

Name: _____ *(Please print)*

Title: _____ *(OT, PT, RESNA, etc.)*

DME Provider Name: _____ *(Please print)*

☞ _____ *(Use Ink - A signature stamp is not acceptable)*

Date:

☞ _____ *(Use Ink - A signature stamp is not acceptable)*

SECTION 10—Clinician attestation and signature/date:

I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.

Clinician’s Signature:

☞ _____ Date: _____

(Use Ink - A signature stamp is not acceptable)

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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. 10/18/18: Department of Health Care Services
B. 09/20/18: Department of Health Care Services
C. 06/26/18: Department of Health Care Services
D. 01/31/18: Department of Health Care Services
E. 07/11/17: Department of Health Care Services
F. 08/23/16: Department of Health Care Services
G. 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
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 Sections 41515.2 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.[I]

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: 1. 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. 2. Psychiatric inpatient hospital services. 3. Targeted Case Management. 4. Psychiatrist services. 5. Psychologist services. 6. 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.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES 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. This APL supersedes APL 18-011.

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]

[1] CCS N.L.s can be found at: https://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). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), 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 continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning 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 – Implemented 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	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed 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 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

[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

determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical 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, 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). WCM counties participating with the MTP will continue to receive a separate allocation for this program and are responsible for care coordination of MTP services.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices. Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[6]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/Pediatric Intensive Care Unit/Neonatal Intensive Care Unit (NICU)

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, as well as all 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,

[6] See the WCM CCS N.L. Category List. is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Index-Category-List-June2018.xls

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 serves as the primary vehicle for ensuring 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. The MOU must include, at a minimum, all of the provisions specified in the MOU template and must be consistent with the requirements of SB 586. MCPs are required to submit an executed MOU to DHCS 105 days prior to implementation. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS members 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, including administrative functions, from the county CCS program to the MCPs.[8] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensuring C.O.C. and services for members who are 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 the Children's Medical Services Net (CMS Net) system 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 C.O.C. of already approved service authorization requests, as required by this APL and applicable state and federal laws.

[7] See footnote 5. The MOU template can be found on the CCS WCM website.
[8] See footnote 4. WIC Section 14094.7(d)(4)(C).

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When a CCS-eligible member moves from one county to another, 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 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 must communicate all resolved disputes in writing to the MCP. 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 CCSRedesign@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 must assess each CCS member'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 removes or limits existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

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[9] See footnote 4. WIC Section 14093.06(b).
[10] Unresolved disputes must be referred to: CCSRedesign@dhcs.ca.gov
[11] See footnote 4. WIC Section 14094.15(d).

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 CCS members enrolling in the MCP, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level through:

   - 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 who 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, as described below:

   <u>New Members and Newly CCS-Eligible Members Determined High Risk</u>
   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.

   <u>Risk Assessment</u>
   The risk assessment process must address:

   - 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;

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- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a 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 identify 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 to be 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, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- 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.

[12] See footnote 4. WIC Section 14094.11(b)(4).

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The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must 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 must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- 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; and
- 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 members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of 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 members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

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 members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a 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 a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[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 must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to 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:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] 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 C.O.C. 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 member's 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 who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

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 member. The MCPs must provide care coordination to 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.

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[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 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. 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 DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- 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. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. 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 an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with 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. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their 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.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

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D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS 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

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] 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 the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. 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. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

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

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

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centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] 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.[34]

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 FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet 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: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

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IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] 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.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] 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
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. 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:[41]

- 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; and
- Procedures to detect both under- and over-utilization of health care services.

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 format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. 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 companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] 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

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. 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 the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Approval of Modifications of CalOptima Policies and Procedures Related to CalOptima's Whole-Child Model Program and Merit-based Incentive Payment System (MIPS) Payment Adjustment

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations (714) 246-8400
Belinda Abeyta, Executive Director, Operations (714) 246-8400

Recommended Action(s)

Approve modifications to the following Policies and Procedures:

A. GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program [Medi-Cal]
B. GG.1318: Coordination of Care for Hemophilia Members [Medi-Cal]
C. GG.1539: Authorization for Out-of-Network and Out-of-Area Services [MC, OC, OCC]
D. MA.3101: Claims Processing [OC, OCC, PACE]

Background and Discussion

As a County Organized Health System (COHS), CalOptima contracts with state and federal agencies to provide health care services to beneficiaries in Orange County. 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

The California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children under age 21 who meet eligibility criteria based on financial and medical conditions. The California Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal Managed Care Plan (MCP) contracts for COHS on a phased-in basis.

On November 9, 2018, DHCS delayed the implementation of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS determined that more time is needed to ensure effective preparation and a robust number of CCS-paneled providers. On December 23, 2018, DHCS released All Plan Letter (APL) 18-023 California Children's Services Whole-Child Model Program, which superseded APL 18-011, originally published on June 7, 2018, and included clarifying language and new guidance regarding Neonatal Intensive Care Unit (NICU), High Risk Infant Follow-up (HRIF) program, pediatric palliative care, and continuity of care appeals.

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On April 4, 2019, the CalOptima Board of Directors authorized modification of existing WCM-related Policies and Procedures to eliminate the age restriction for members who are diagnosed with Hemophilia, End Stage Renal Disease, or are identified as eligible for a transplant consistent with the DHCS-approved commencement date of the CalOptima WCM program to no sooner than July 1, 2019. Additional policies and procedure require modification due to the delayed WCM implementation date and regulatory guidance.

Below is a summary of the modified policies related to WCM:

A. ***GG.1101: California Children's Services*** **(CCS)/Whole-Child Model – Coordination with County CCS Program** defines the guidelines for coordination of care between CalOptima or a health network and the County California Children's Services (CCS) program for members eligible with the CCS program and transitioned into the WCM program, newly CCS-eligible members, or new CCS members enrolling in CalOptima, including identification and referral of members with CCS-eligible conditions. CalOptima revised this policy to ensure compliance with the DHCS APL 18-023: California Children's Services Whole-Child Model Program. With respect to WCM, the revisions address CalOptima's expanded responsibility for determining HRIF program eligibility, coordinating and authorizing HRIF services, and ensuring the provision of HRIF case management service in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model. The revisions also address the addition of CalOptima as a liaison between practitioners/Health Networks and the County for medical eligibility determination referrals.

B. ***GG.1318: Coordination of Care for Hemophilia Members*** defines the case management guidelines for coordination of care by CalOptima and its Health Networks for Members diagnosed with Hemophilia. CalOptima has revised the policy pursuant the DHCS APL 18-023: California Children's Services Whole-Child Model Program. The WCM implementation date has been revised in the policy and effectuates CalOptima's responsibility for care coordination for member diagnosed with Hemophilia and are less than twenty-one years of age.

C. ***GG.1539: Authorization for Out-of-Network and Out-of-Area Services*** describes requirements and process for authorization of out-of-network and out-of-area Covered Services for Members assigned to CalOptima Direct or a Health Network. CalOptima revised this policy with respect to Whole-Child Model to be compliant with the DHCS APL 18-023: California Children's Services Whole-Child Model. The revisions ensure WCM members rights to access out-of-network providers in order to obtain Medically Necessary Covered Services if they follow the appropriate process and CalOptima or a Health Network is unable to provide the needed service. The revisions ensure that CalOptima or a Health Network cannot deny out-of-network services based upon cost or location.

<u>Merit-based Incentive Payment System (MIPS) Adjustments</u>
The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) requires CMS to implement an incentive program, referred to as the Quality Payment Program; which provides two participation tracks for non-contracted (out-of-network) clinicians:

Advanced Alternative Payment Models (APMS) and Merit-based Incentive Payment System (MIPS). Guidance regarding APMS is forthcoming. Guidance regarding MIPS was first received on April 27, 2018 with subsequent updates on November 8, 2018 and January 8, 2019.

The MIPS was created to reform Medicare Part B payments by rewarding the delivery of high-quality patient care provided by non-contracted clinicians. CMS evaluates eligible clinicians and adjusts payment based upon following performance categories: Quality, Promoting Interoperability, Improvement Activities, and Cost. Evaluation is conducted on an annual basis and the maximum MIPS adjustment percentages increase year over year. The following table provides an overview of the positive and negative MIPS adjustments which can have a range of percentages with a maximum limit for each payment year from 2019-2022:

Performance Year	Payment Year	Maximum Limit for MIPS adjustment
January 1, 2017 - December 31, 2017	2019	+/-4 percent
January 1, 2018 - December 31, 2018	2020	+/-5 percent
January 1, 2019 - December 31, 2019	2021	+/-7 percent
January 1, 2020 - December 31, 2020	2022	+/-9 percent

Below is a summary of the modified policy related to MIPS payment adjustments:

A. ***MA.3101: Claims Processing*** outlines the criteria and process to ensure the timely and accurate processing and adjudication of claims in accordance with applicable statutory and regulatory guidelines for contracted and non-contracted providers. CalOptima revised this policy pursuant to the CalOptima review process to ensure alignment with current operations to include MIPS payment adjustments requirements for non-contracted providers, for both CalOptima and its Health Networks. This policy will apply to MIPS program requirements beginning January 2019 and beyond.

Fiscal Impact
The proposed revisions to CalOptima Policies GG.1101, GG.1318, GG.1539 and MA.3101 are operational and compliance-related in nature. Staff does not anticipate any additional fiscal impact to the CalOptima Consolidated FY 2019-20 Operating Budget, approved by the Board on June 6, 2019.

Rationale for Recommendation
The recommended actions will enable CalOptima to meet regulatory and business requirements of the Whole-Child Model program and MIPS payment adjustments.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program [Medi-Cal] (redline and clean)
2. GG.1318: Coordination of Care for Hemophilia Members [Medi-Cal] (redline and clean)
3. GG.1539: Authorization for Out-of-Network and Out-of-Area Services [MC, OC, OCC] (redline and clean)
4. MA.3101: Claims Processing [OC, OCC, PACE] (redline and clean)
5. Board Action April 4, 2019, Consider Actions Related to CalOptima's Whole-Child Model (WCM) Program
6. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program
7. CMS HPMS Memo: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

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Policy #: GG.1101
Title: **California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 10/01/1995
~~Last Review Date:~~ ~~11/01/17~~
~~Last~~ Revised Date: ~~11/01/17~~07/01/2019

I. PURPOSE

This policy defines the guidelines for coordination of care between CalOptima or a **Health Network** and the ~~County~~ **California Children's Services (CCS)** ~~for Children with Special~~program.

II. POLICY

A. Effective July 01, 2019, CalOptima shall implement ~~on~~ the Department of Health Care ~~Needs.~~Services (DHCS)-approved **Whole-Child Model (WCM)** program. CalOptima shall assume responsibility for **CCS** for **Members** who are eligible for the **California Children's Services (CCS)** program and transitioned into the **WCM** program, newly **CCS-eligible members**, or new **CCS members** enrolling in CalOptima, including the identification and referral of **Members** with **CCS-eligible Cconditions**.

~~II. POLICY~~

B. With respect to the **WCM** program, CalOptima and the **Health Networks** shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as the California DHCS guidance, including, but not limited to, All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima and the **Health Networks** shall:

1. Use all current and applicable **CCS** ~~provides~~program guidelines, including **CCS** program regulations, **CCS** program information notices, and **CCS** numbered letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.

2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the **Member's CCS-eligible Condition** in cases in which applicable **CCS** clinical guidelines do not exist.

C. CalOptima shall enter into a memorandum of understanding (MOU), or other agreement, with the County **CCS** program for the coordination of **CCS** services to **Members**.

D. CalOptima shall convene a quarterly meeting between CalOptima and the local **CCS** p~~P~~rogram in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services ~~Program~~/Whole Child Model.

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E. CalOptima or a **Health Network** shall assume responsibility for the **WCM** program as follows:

1. 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 enrolled **Members**.

2. Providing all supporting medical documentation and information needed for **CCS** annual medical eligibility redetermination and other medical determinations.

3. Providing all **Member** information in a Transfer Packet to the County **CCS** p~~P~~rogram to facilitate inter-county transfer in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services/Whole-Child Model.

4. High Risk Infant Follow-Up (HRIF) program, including determining HRIF program eligibility, coordinating and authorizing HRIF services for **Members** in accordance with CCS N.L. 05-1016: High Risk Infant Follow-Up (HRIF) Program Services, or any superseding CCS N.L., and ensuring the provision of HRIF **Case Management**~~,~~ services in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services ~~Program~~/Whole Child Model.

F. County **CCS** Program WCM responsibilities, include but are not limited to:

1. **CCS** program eligibility determination, including responding to and tracking appeals related to **CCS** program medical eligibility determinations and redeterminations; and

~~1.~~2. Care coordination for Medical Therapy Program (MTP) services, receiving and processing referrals to the MTP (except for review and authorization of durable medical equipment, including custom and specialized durable medical equipment, and related supplies), physical and occupational therapy services provided at the Medical Therapy Units (MTU), medical therapy conference services, and financial assistance to **Members** under the age of twenty-one (21) who are eligible for ~~CCS services~~MTP.

3. Notify CalOptima ~~shall enter into a memorandum~~ of ~~understanding (MOU), or other agreement, with~~ a new **CCS-eligible** inter-county transfer **Member** via a Transfer Packet.

G. DHCS **WCM** responsibilities include but are not limited to:

1. Review and final determination of unresolved disagreements between CalOptima and the ~~local~~County **CCS** program ~~for the coordination of CCS services to Members.~~relative to **CCS** medical eligibility.

~~B.~~ If a **Member** has **Other Health Coverage (OHC),** CalOptima~~,~~ or a **Health Network**~~, or a Practitioner,~~ shall ~~identify Members who may have a CCS-Eligible Condition.~~

~~C.~~ consider the **OHC** plan as the **Member's** primary health plan. CalOptima~~,~~ or a **Health Network**~~, or a Practitioner, shall refer a Member to CCS within twenty-four (24) hours, or the next working day, after determining that~~ shall remain the ~~Member may have a CCS-Eligible Condition.~~

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~~D. A Member's Primary Care Practitioner (PCP), Health Network, or Practitioner, shall refer the Member to 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 CCS-Eligible Condition.~~

~~E. CalOptima or a Health Network is not responsible for the provision or payment of services authorized by CCS for the treatment of a CCS-Eligible Condition, after CCS determines that the Member is eligible for CCS.~~

~~a. CCS shall only reimburse CCS-paneled Providers and CCS-approved hospitals, for services authorized by CCS, for the treatment of a CCS-Eligible Condition.~~

~~F. CalOptima or a Health Network shall provide the following:~~ secondary health plan

~~1. Provision and payment of Covered Services related to the identification, evaluation,~~ and ~~diagnosis of a CCS-Eligible Condition;~~

~~2. Covered Services 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~~

H. ~~Covered Services for a Member if CCS does not approve eligibility,~~payer of last resort in accordance with ~~Section III.E. of this policy.~~CalOptima Policy FF.2003: Coordination of Benefits.

~~G. CalOptima or a Health Network shall designate a case manager to serve as a liaison to CCS to help coordinate services with CCS.~~

I. CalOptima or a **Health Network** shall proactively ~~collaborate with CCS to~~ coordinate transition services for a ~~Member reaching twenty-one (21~~**WCM Member** who loses Medi-Cal eligibility to the ~~-~~County **CCS** program for ongoing health care and **Case Management** services.

1. CalOptima or a **Health Network** shall notify the County **CCS** program in writing, within fifteen (15) calendar days, of **CCS**-eligible neonates, infants, and children up to three (3) years of age~~, from CCS to CalOptima Direct, a Health Network, or the Genetically Handicapped Persons Program (GHPP).~~that lose Medi-Cal coverage.

~~H. 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.~~

III. PROCEDURE

A. A **Practitioner** shall perform appropriate baseline health assessments and diagnostic evaluations to identify potential **CCS-**~~Eligible Conditions~~**eligible Conditions** in accordance with CalOptima Policy GG.1116: Pediatric Preventive Services.

B. CalOptima or a **Health Network** shall provide:

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1. Training and resources to **Primary Care Physician** and other **Primary Care Providers** to ensure timely identification of **Members** with potential **CCS-eligible Conditions** and notification to the ~~-~~County **CCS** program;

2. Provision and payment~~may~~ of **Medically Necessary Covered Services** related to the identification, evaluation, and diagnosis of a **CCS-eligible Condition**;

3. **Medically Necessary Covered Services** whether related or unrelated to a **Member's CCS-eligible Condition**;

4. Authorization and reimbursement of only **CCS**-paneled physicians and **CCS**-approved facilities for the treatment of **CCS-eligible Conditions**, 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.

~~1.~~5. CalOptima or a **Health Network** shall identify ~~a Member~~**Members** who may have a **CCS-eligible Condition** through ~~a referral which may be made through,~~various means, including but ~~is~~ not limited to:

~~2. Utilization Management;~~

~~3. Case Management;~~

~~4. PCP;~~

~~5. Specialist;~~

~~6. Pharmacy; and~~

~~7. Disease Management.~~

a. 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;

b. Screening of all **Members** referred for **Case Management, Disease Management**, and/-or **Population Health Management** services or who are currently enrolled in a **Case Management**, **Disease Management,** or **Population Health Management** program; and

c. Review of pharmacy data.

~~B.~~C. CalOptima~~, a Health Network, or a Practitioner,~~ shall refer a **Member** to ~~CCS~~the County **CCS** program for initial and annual medical eligibility determination after identifying ~~and determining~~ that the **Member's** medical condition may qualify him or her for **CCS**.

~~C.~~D. ~~CalOptima, a~~A **Health Network**~~, or a Practitioner,~~ shall refer a **Member** ~~to~~for initial and annual **CCS** medical eligibility determination through CalOptima by~~ completing the following steps:~~:

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~~A. Contacting the Member's PCP and requesting the Member's Medical Records;~~

~~4.~~1. ~~Ensuring the completion of~~Completing a Service Authorization Request (SAR) form~~, identifying which services the Member may be eligible for, and~~ and submitting the ~~SAR to the Orange County CCS office~~request to CalOptima; and

2. Ensuring the submission of all supporting medical documentation and information needed ~~by CCS to~~ to determine **CCS** medical eligibility and to determine the **Medical Necessity** of the services requested.

3. CalOptima shall facilitate the **CCS** medical eligibility determination by the County **CCS** program by submitting the New Referral **CCS** GHPP Client Service Authorization Request (SAR) and supporting medical documentation to the County **CCS** program.

E. CalOptima shall refer a **Member** to the County CCS program within twenty-four (24) hours, or the next working day, after determining that the **Member** may have a **CCS-eligible Condition**, as described in Section III.D. of this policy.

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 CalOptima for transmittal to the County **CCS** program for **CCS** eligibility determination, as set forth in Section III.D. of this policy, and not wait until the annual **CCS** medical eligibility determination period.

G. The County **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 **Health Network** within twenty-four (24) hours of receipt of the County **CCS** program~~'s~~ **CCS** medical eligibility determination.

H. Disagreements between CalOptima and the County **CCS** program regarding **CCS** medical eligibility determinations must be resolved by the County **CCS** program, in consultation with DHCS. The local **CCS** program shall communicate all resolved disputes in writing to CalOptima in a timely manner. Disputes between CalOptima and the County **CCS** program that are unable to be resolved will be referred by either entity to DHCS.

I. **Members** appealing a **CCS** eligibility determination must appeal to the County **CCS** program.

J. **Member** Grievances

1. CalOptima shall ensure **Members** are provided information on and are provided the same grievances, appeals and state fair hearing rights as provided under state and federal law and in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

K. Provider Grievances

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1. CalOptima or a **Health Network** shall address and resolve **CCS** provider complaints, including but not limited to disputes or grievances concerning the processing of a payment or non-payment of a claim by **CalOptima** or **Health Network** in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint. CalOptima or a Health Network shall communicate the resolution process ~~the SAR~~to all of its **CCS** providers.

~~D. If a Member is approved for CCS:~~

~~1. A~~ CalOptima or a **Health Network** ~~case manager~~ shall ~~help~~proactively coordinate ~~the Member's 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 and approved by a CalOptima or Health Network Medical Director prior 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. 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.~~

~~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.~~

L. ~~CalOptima, or a Member's Health Network, shall contact a Member at least one hundred twenty (120) calendar days prior to the~~a **WCM Member** reaching twenty-one (21) years of age ~~to help transition services from CCS to CalOptima Direct, a Health Network, or GHPP~~, 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.

M. CalOptima or a **Health Network** shall ensure the development of an **Individual Care Plan (ICP)**, **Case Management**, care coordination, and risk stratification in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services ~~program~~/Whole-Child Model.

N. 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

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GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

O. CalOptima or a **Health Network** shall ensure the provision of the **Maintenance** and **T~~t~~ransportation** 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.

P. CalOptima and its **Health Network** 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.

Q. 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.

IV. ATTACHMENT(S)

A. Application to Determine CCS Program Eligibility
B. New Referral CCS~~/~~ GHPP Client Service Authorization Request (SAR)

V. REFERENCES

A. CalOptima Contract for Health Care Services
~~A.~~B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B. CalOptima Contract for Health Care Services~~
C. CalOptima Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency
D. CalOptima Memorandum of Understanding with Orange County Health ~~Network Service Agreement~~Care Agency for Whole Child Model
~~E. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9~~
~~California Welfare and Institutions Code §§14093.06(b) and 14094.15(d)~~
E. CalOptima Policy FF.2003: Coordination of Benefits
F. CalOptima Policy GG.1116: Pediatric Preventive Services
G. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
H. CalOptima Policy GG.1330: Case Management – California Children's Services ~~-~~/Whole-Child Model
I. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
J. CalOptima Policy GG.1508: Authorization and Processing of Referrals
K. CalOptima Policy GG.1510: Appeals Process
L. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
M. CalOptima Policy GG.1547: Maintenance and Transportation
N. CalOptima Policy GG.1600: Access and Availability Standards
O. CalOptima Policy GG.1619: Delegation Oversight
P. CalOptima Policy HH.1101: CalOptima Provider Complaint

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Q. CalOptima Policy HH.1102: Member Grievance
R. CalOptima Policy HH.1108: State Hearing Process and Procedures
S. CCS Numbered Letter 05-1016: High Risk Infant Follow Up (HRIF) Program Services
T. Department of Health Care Services (DHCS) All Plan Letter 18-023: California Children's Services Whole Child Model Program
U. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9
V. Welfare and Institutions Code §§14093.06(b) and 14094.15(d)
~~A. CCS Numbered Letter 05-1016: High Risk Infant Follow Up (HRIF) Program Services~~

VI. REGULATORY AGENCY APPROVAL(S)

A. 03/11/19: Department of Health Care Services
B. 11/02/18: Department of Health Care Services
~~A.~~C. 12/10/15: Department of Health Care Services

VII. BOARD ACTION(S)

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

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~ #	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	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 (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal
Reinstated	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	07/01/2019	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal

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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~~ 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 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~~members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
~~Children with Special Health Care Needs~~Case Management	~~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).~~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.
Continuity of Care	Services provided to a member rendered by an out-of-network provider with whom the member has pre-existing provider relationship.
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~~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~~members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

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Term	Definition
Disease Management	A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that: 1. Supports the physician/Member relationship; 2. Emphasizes prevention of exacerbation and complications utilizing cost-effective and evidence-based practice guidelines and Member empowerment strategies such as self-management; and 3. Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving health.
~~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~~covered services to ~~Members~~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.
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.
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~~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~~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.

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Term	Definition
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.
Population Health Management (PHM)	A model of care that strives to address patients' health needs at all points along the continuum of care, including the community setting, by increasing patient participation and engagement and targeting interventions.
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.~~covered services.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to ~~Members~~members and serves as the medical home for ~~Members~~members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For ~~Members~~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).~~.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
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.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Policy #:	GG.1101
Title:	**California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/1995
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the guidelines for coordination of care between CalOptima or a **Health Network** and the County **California Children's Services (CCS)** program.

II. POLICY

A. Effective July 01, 2019, CalOptima shall implement the Department of Health Care Services (DHCS)-approved **Whole-Child Model (WCM)** program. CalOptima shall assume responsibility for **CCS** for **Members** who are eligible for the **California Children's Services (CCS)** program and transitioned into the **WCM** program, newly **CCS-eligible members**, or new **CCS members** enrolling in CalOptima, including the identification and referral of **Members** with **CCS-eligible Conditions**.

B. With respect to the **WCM** program, CalOptima and the **Health Networks** shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as the California DHCS guidance, including, but not limited to, All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima and the **Health Networks** shall:

1. Use all current and applicable **CCS** program guidelines, including **CCS** program regulations, **CCS** program information notices, and **CCS** numbered letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.

2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the **Member's CCS-eligible Condition** in cases in which applicable **CCS** clinical guidelines do not exist.

C. CalOptima shall enter into a memorandum of understanding (MOU), or other agreement, with the County **CCS** program for the coordination of **CCS** services to **Members**.

D. CalOptima shall convene a quarterly meeting between CalOptima and the local **CCS** program in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services/Whole Child Model.

E. CalOptima or a **Health Network** shall assume responsibility for the **WCM** program as follows:

1. Authorization and payment of **CCS**-eligible medical services, including authorization activities, claims processing and payment, **Case Management**, and quality oversight and

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coordination of all Medi-Cal and **CCS**-covered services, as well as **Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)**, for enrolled **Members**.

2. Providing all supporting medical documentation and information needed for **CCS** annual medical eligibility redetermination and other medical determinations.

3. Providing all **Member** information in a Transfer Packet to the County **CCS** program to facilitate inter-county transfer in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services/Whole-Child Model.

4. High Risk Infant Follow-Up (HRIF) program, including determining HRIF program eligibility, coordinating and authorizing HRIF services for **Members** in accordance with CCS N.L. 05-1016: High Risk Infant Follow-Up (HRIF) Program Services, or any superseding CCS N.L., and ensuring the provision of HRIF **Case Management** services in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services/Whole Child Model.

F. County **CCS** Program WCM responsibilities, include but are not limited to:

1. **CCS** program eligibility determination, including responding to and tracking appeals related to **CCS** program medical eligibility determinations and redeterminations; and

2. Care coordination for Medical Therapy Program (MTP) services, receiving and processing referrals to the MTP (except for review and authorization of durable medical equipment, including custom and specialized durable medical equipment, and related supplies), physical and occupational therapy services provided at the Medical Therapy Units (MTU), medical therapy conference services, and financial assistance to **Members** under the age of twenty-one (21) who are eligible for MTP.

3. Notify CalOptima of a new **CCS-eligible** inter-county transfer **Member** via a Transfer Packet.

G. DHCS **WCM** responsibilities include but are not limited to:

1. Review and final determination of unresolved disagreements between CalOptima and the County **CCS** program relative to **CCS** medical eligibility.

H. If a **Member** has **Other Health Coverage (OHC)**, CalOptima or a **Health Network** shall consider the **OHC** plan as the **Member's** primary health plan. CalOptima or a **Health Network** shall remain the secondary health plan and payer of last resort in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

I. CalOptima or a **Health Network** shall proactively coordinate transition services for a **WCM Member** who loses Medi-Cal eligibility to the County **CCS** program for ongoing health care and **Case Management** services.

1. CalOptima or a **Health Network** shall notify the County **CCS** program in writing, within fifteen (15) calendar days, of **CCS**-eligible neonates, infants, and children up to three (3) years of age, that lose Medi-Cal coverage.

III. PROCEDURE

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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:

1. Training and resources to **Primary Care Physician** and other **Primary Care Providers** to ensure timely identification of **Members** with potential **CCS-eligible Conditions** and notification to the County **CCS** program;

2. Provision and payment of **Medically Necessary Covered Services** related to the identification, evaluation, and diagnosis of a **CCS-eligible Condition**;

3. **Medically Necessary Covered Services** whether related or unrelated to a **Member's CCS-eligible Condition**;

4. Authorization and reimbursement of only **CCS**-paneled physicians and **CCS**-approved facilities for the treatment of **CCS-eligible Conditions**, 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.

5. CalOptima or a **Health Network** shall identify **Members** who may have a **CCS-eligible Condition** through various means, including but not limited to:

a. 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;

b. Screening of all **Members** referred for **Case Management, Disease Management**, and/or **Population Health Management** services or who are currently enrolled in a **Case Management**, **Disease Management,** or **Population Health Management** program; and

c. Review of pharmacy data.

C. CalOptima shall refer a **Member** to the County **CCS** program for initial and annual medical eligibility determination after identifying that the **Member's** medical condition may qualify him or her for **CCS**.

D. A **Health Network** shall refer a **Member** for initial and annual **CCS** medical eligibility determination through CalOptima by:

1. Completing a Service Authorization Request (SAR) form and submitting the request to CalOptima; and

2. 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 requested.

3. CalOptima shall facilitate the **CCS** medical eligibility determination by the County **CCS** program by submitting the New Referral **CCS** GHPP Client Service Authorization Request (SAR) and supporting medical documentation to the County **CCS** program.

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E. CalOptima shall refer a **Member** to the County CCS program within twenty-four (24) hours, or the next working day, after determining that the **Member** may have a **CCS-eligible Condition**, as described in Section III.D. of this policy.

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 CalOptima for transmittal to the County **CCS** program for **CCS** eligibility determination, as set forth in Section III.D. of this policy, and not wait until the annual **CCS** medical eligibility determination period.

G. The County **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 **Health Network** within twenty-four (24) hours of receipt of the County **CCS** program **CCS** medical eligibility determination.

H. Disagreements between CalOptima and the County **CCS** program regarding **CCS** medical eligibility determinations must be resolved by the County **CCS** program, in consultation with DHCS. The local **CCS** program shall communicate all resolved disputes in writing to CalOptima in a timely manner. Disputes between CalOptima and the County **CCS** program that are unable to be resolved will be referred by either entity to DHCS.

I. **Members** appealing a **CCS** eligibility determination must appeal to the County **CCS** program.

J. **Member** Grievances

1. CalOptima shall ensure **Members** are provided information on and are provided the same grievances, appeals and state fair hearing rights as provided under state and federal law and in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

K. Provider Grievances

1. CalOptima or a **Health Network** shall address and resolve **CCS** provider complaints, including but not limited to disputes or grievances concerning the processing of a payment or non-payment of a claim by **CalOptima** or **Health Network** 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.

L. 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/Whole-Child Model.

M. CalOptima or a **Health Network** shall ensure the development of an **Individual Care Plan (ICP)**, **Case Management**, care coordination, and risk stratification in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services/Whole-Child Model.

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N. 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: Continuity of Care for Members Transitioning into CalOptima Services and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

O. 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.

P. CalOptima and its **Health Network** 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.

Q. 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.

IV. ATTACHMENT(S)

A. Application to Determine CCS Program Eligibility
B. New Referral CCS GHPP Client Service Authorization Request (SAR)

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency
D. CalOptima Memorandum of Understanding with Orange County Health Care Agency for Whole Child Model
E. CalOptima Policy FF.2003: Coordination of Benefits
F. CalOptima Policy GG.1116: Pediatric Preventive Services
G. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
H. CalOptima Policy GG.1330: Case Management – California Children's Services/Whole-Child Model
I. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
J. CalOptima Policy GG.1508: Authorization and Processing of Referrals
K. CalOptima Policy GG.1510: Appeals Process
L. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
M. CalOptima Policy GG.1547: Maintenance and Transportation
N. CalOptima Policy GG.1600: Access and Availability Standards
O. CalOptima Policy GG.1619: Delegation Oversight
P. CalOptima Policy HH.1101: CalOptima Provider Complaint
Q. CalOptima Policy HH.1102: Member Grievance
R. CalOptima Policy HH.1108: State Hearing Process and Procedures
S. CCS Numbered Letter 05-1016: High Risk Infant Follow Up (HRIF) Program Services

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T. Department of Health Care Services (DHCS) All Plan Letter 18-023: California Children's Services Whole Child Model Program
U. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9
V. Welfare and Institutions Code §§14093.06(b) and 14094.15(d)

VI. REGULATORY AGENCY APPROVAL(S)

A. 03/11/19: Department of Health Care Services
B. 11/02/18: Department of Health Care Services
C. 12/10/15: Department of Health Care Services

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
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 (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal
Reinstated	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	07/01/2019	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal

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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.
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.
Continuity of Care	Services provided to a member rendered by an out-of-network provider with whom the member has pre-existing provider relationship.
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.
Disease Management	A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that: 1. Supports the physician/Member relationship; 2. Emphasizes prevention of exacerbation and complications utilizing cost-effective and evidence-based practice guidelines and Member empowerment strategies such as self-management; and 3. Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving health.
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.

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Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to members assigned to that Health Network.
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.
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.
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.
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.
Population Health Management (PHM)	A model of care that strives to address patients' health needs at all points along the continuum of care, including the community setting, by increasing patient participation and engagement and targeting interventions.
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.

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Term	Definition
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
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.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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INFORMATION ABOUT CALIFORNIA CHILDREN'S SERVICES (CCS)

What is California Children's Services?

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Care Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

What does CCS offer children?

If you or your child's doctor think that your child might have a CCS-eligible medical condition, CCS may pay for or provide a medical evaluation to find out if your child's condition is covered.

If your child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances and medical equipment.
- Medical case management to help get special doctors and care for your child when medically necessary, and referral to other agencies, including public health nursing and regional centers; or a
- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in public schools for children who are medically eligible.

Who qualifies for CCS?

The program is open to anyone who:

- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of less than $40,000 as reported on the adjusted gross income on the state tax form **or** whose out-of-pocket medical expenses for a child who qualifies are **expected** to be more than 20 percent of family income.

Family income is not a factor for children who:

- need diagnostic services to confirm a CCS eligible medical condition; or
- were adopted with a known CCS eligible medical condition; or
- are applying only for services through the Medical Therapy Program; or
- have Medi-Cal full scope, no share of cost.

What medical conditions does CCS cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain criteria that determine if your child's medical condition is eligible. Listed below are categories of medical conditions that may be covered and **some examples** of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Disorders of the genito-urinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care

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• Disorders of the skin and subcutaneous tissue (severe hemangioma)
• Medically handicapping malocclusion (severely crooked teeth)
Ask your county CCS office if you have questions.

What must the applicant or family do to qualify?

Families (or the applicant if age 18 or older, or an emancipated minor) must:

• complete the application form on page 3 and return it to their county CCS office;
• give CCS all of the information requested so CCS can determine if the family qualifies;
• apply to Medi-Cal if CCS believes that a family's income qualifies them for the Medi-Cal program. (If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.)

How is my privacy protected?

California law requires that families applying for services be given information on how CCS protects their privacy.[1]

To protect your privacy:

• CCS must keep this information confidential.[2]

• CCS may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and CCS records concerning you or your child. If you wish to see these records contact your county CCS office. By law, the information you give CCS is kept by the program.[3]

Do I have a right to appeal a decision?

You have the right to disagree with decisions made by CCS.[4] This is called an appeal. The appeal process gives the parent/legal guardian or applicant a way to work with the CCS program to find solutions to disagreements. For information on the appeal process, contact your county CCS office.

Where can I get more information about CCS?

For more information, or help in filling out this application, please contact your county CCS office. Their phone number is usually listed in the government section of your local telephone directory. Look under California Children's Services or county Health Department.

Notes
1 Civil Code, Section 1798.17
2 In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250–6255)
3 Section 123800 et. seq. of the California Health and Safety Code
4 California Code of Regulations, Title 2, Chapter 13, Sections 42702–42703

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APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term "applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. Please type or print clearly.

A. Applicant Information

1. Name of Applicant (last) (first) (middle)	Name on birth certificate (if different)	Any other name the applicant is known by

2. Date of birth (month, day, year)	3. Place of birth - county and state	Country, if born outside the U.S.

4. Applicant's residence address (number, street) (do not use a P.O. Box)	City	County	Zip Code

5. Gender	6. Race/Ethnicity	7. Social security number (optional)

8. What is the applicant's suspected eligible CCS condition or disability?

9. Primary Care Physician	10. Physician's phone number

B. Parent/Legal Guardian/Family Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian	12. Mother's first name (if not identified in 11)	Maiden name

13. Residence address (number, street) (do not use a P.O. Box)	City	County	Zip Code

14. Mailing address (if different from 13)	City	County	Zip Code

15. Home phone number	16. Cell phone number	17. Work phone number	18. What language do you speak at home?
( )	( )	( )	

19. Email address	20. Number of persons in family unit

21. Other Parent Name and Address if not living with the applicant

C. Health Insurance Information

22. Does the applicant have Medi-Cal? ☐ Yes ☐ No	23. If yes, what is the applicants Medi-Cal number?	24. Is there a share-of-cost? ☐ Yes ☐ No	25. If yes, what is the amount you pay per month? $

26a. Does the applicant have other health insurance? ☐ Yes ☐ No	26b. If yes, what is the name of the insurance plan or company?	26c. Policy or Plan Number

27. Type of insurance plan or company
☐ Preferred Provider Organization (PPO) ☐ Health Maintenance Organization (HMO) ☐ Other: _____

28. Does the applicant have dental insurance? ☐ Yes ☐ No	29. Does the applicant have vision insurance? ☐ Yes ☐ No

D. Certification (Initial and sign below. Your signature authorizes the CCS program to proceed with this application.)

_____I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of applicant by the CCS program.

_____I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

_____I certify that I have read and understand the information or have had it read to me.

_____I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date

Signature of witness (only if the person signed with a mark)	Date

INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION FORM (DHCS 4480)

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, please contact your county CCS office.

Once the application is completed, mail it to your county CCS office. Remember to sign and date the form.

Section A: Applicant Information ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested.)

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next Box, write the applicant's full name as it appears on his/her birth certificate if different from his/her name. If the applicant is known by any other name, please include that name in the last box.

2. **Applicant's date of birth:** Write the month, day, and year of the applicant's birth.

3. **Place of birth:** Write the county and state where applicant was born. Include the country if the applicant was born outside the U.S.

4. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Please do not use a P.O. Box.

5. **Applicant's gender:** Place a checkmark or an X in the correct gender box (male or female).

6. **Race/Ethnicity:** Please enter the category from the following list which best describes the applicant's primary race/ethnicity:

- Alaskan Native
- Amerasian
- American Indian
- Asian
- Asian Indian
- Black/African American
- Cambodian
- Chinese
- Filipino
- Guamanian
- Hawaiian
- Hispanic/Latino
- Japanese
- Korean
- Laotian
- Samoan
- Vietnamese
- White
- Other

7. **Applicant's social security number *(optional)*:** Please write the applicant's nine-digit social security number.

8. **Suspected CCS condition or disability:** Write the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on page 1). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.

9. **Name of applicant's primary care physician:** Write the name of the applicant's physician.

10. **Physician's phone number:** Write the phone number for the physician listed in number 9.

Section B: Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).

12. **Mother's first name and maiden name:** Write the applicant's mother's first name and maiden name.

13. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Please do not use a P.O. Box.

14. **Mailing address:** If this address is different from number 13, please write the street number, street name, city, and ZIP code.

15. **Home phone number:** Please write the home phone number where you can be reached.

16. **Cell phone number:** Please write the cell phone number where you can be reached.

17. **Work phone number:** Please write the work phone number where you can be reached.

18. **Language(s) spoken:** Write the language you speak **at home**.

19. **Email address**: Write the email address for the parent or legal guardian.

20. **Number of persons in family unit:** Write the number of persons living in the same household.

21. **Other Parent Name and Address if not living with the applicant:** Write the name and address for a second contact person.

Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

22. If the applicant does not receive Medi-Cal, check "No" and go to number 26a. If the applicant receives Medi-Cal, check "Yes" and fill in the applicant's Medi-Cal number.

23. If you the applicant has Medi-Cal, enter the 14 digit Medi-Cal number.

24. If you pay a portion of the cost of your Medi-Cal insurance, check "Yes".

25. If you pay a portion of the chare of cost, fill in the monthly amount paid.

26a. If the applicant does not have other health insurance, check "No" and go to number 28.

26b. If the applicant has health insurance, fill in the name of the insurance plan or company.

26c. If the applicant has health insurance, fill in the policy or plan number.

27. If the applicant has health insurance, check the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, you can call your health insurance company and ask them.

28. If the applicant has dental insurance, check "Yes." If the applicant does not have dental insurance, check "No."

29. If the applicant has vision insurance, check "Yes." If the applicant does not have vision insurance, check "No."

Section D: Certification

Be sure to sign and date in ink. If signature is signed with a mark, please have a witness sign his or her signature and fill in the date.

Under "Relationship to the applicant," enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

Submitting Your Application

Mail or deliver your application to your county CCS office. To find your county CCS office, go to www.dhcs.ca.gov/services/ccs or look in the government section of your local telephone directory under California Children's Services or county health department.

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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
Additional 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

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 like 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.

Policy #: GG.1318
Title: **Coordination of Care for Hemophilia Members**
Department: Medical Affairs
Section: Case Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/2006
~~Last Review Date:~~ ~~04/01/18~~
~~Last~~ Revised Date: ~~04/01/18~~10/03/2019

DRAFT_20191003BOD_Concurrent DHCS Review

I. PURPOSE

This policy defines the case management guidelines for coordination of care by CalOptima and its Health Networks for Members diagnosed with Hemophilia.

II. POLICY

A. This policy shall apply to Medi-Cal Members age twenty-one (21) and over, until implementation of the Whole-Child Model program, at which time it shall apply to Medi-Cal Members of any age.

~~A.~~B. CalOptima is responsible for providing case management to a CalOptima Direct ~~Direct~~ Member who is ~~at least twenty-one (21) years of age and at least twenty-one (21) years of age and~~ diagnosed with Hemophilia, in accordance with the provisions of this policy.

~~B.~~C. If a Health Network Member, except a Kaiser Member, ~~is at least twenty-one (21) years of age and is at least twenty-one (21) years of age and~~ is diagnosed with Hemophilia, CalOptima shall transition such Member to CalOptima Direct, in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.

~~C.~~D. A CalOptima Direct ~~Direct~~ Member who is ~~at least twenty-one (21) years of age and at least twenty-one (21) years of age and~~ diagnosed with Hemophilia shall receive care from a Federal Hemophilia Treatment Center, in accordance with the provisions of this policy.

E. A CalOptima Direct ~~Direct~~ Member who is ~~at least twenty-one (21) years of age and at least twenty-one (21) years of age and~~ diagnosed with Hemophilia shall receive Hemophilia factor from a Pharmacy that is registered as a covered entity in the 340B Drug Pricing Program.

~~The age provision shall no longer apply on and after the implementation date of the Department of Health Care Services approved Whole Child Model program.~~
~~D.~~

III. PROCEDURE

A. A Provider is responsible for diagnosing a Member with Hemophilia.

B. Upon receipt of notice of a Member who is ~~at least twenty-one (21) years of age and at least twenty-one (21) years of age and~~ diagnosed with Hemophilia, a Health Network (except Kaiser Health Foundation) shall:

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1. Notify CalOptima's Case Management Department via secure email within five (5) business days after identification of such Member; and

2. Provide Case Management to the Member until the Member is effectively transitioned to CalOptima Direct.

C. Upon receipt of a written notice from a Health Network as set forth in Section III.B of this policy:

1. CalOptima's Case Management Department shall open a case for oversight until the Member transitions to CalOptima Direct;

2. CalOptima's Case Manager shall submit a Change of Network Request (CONR) to CalOptima's Medi-Cal Enrollment and Reconciliation Department inbox to request Health Network assignment to CalOptima Direct (COD);

3. CalOptima's Medi-Cal Enrollment and Reconciliation Department shall transition the Member to CalOptima Direct as set forth in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct; and

4. CalOptima shall notify the Member of the transition to CalOptima Direct within five (5) business days after receipt of notice from the Health Network.

D. CalOptima shall provide case management and care coordination to a Member who is not a Kaiser Member and is ~~at least twenty-one (21) years of age and~~ ~~at least twenty-one (21) years of age and~~ diagnosed with Hemophilia as follows:

1. CalOptima's Case Management Department shall contact the Member by telephone within (10) business days after transition to CalOptima Direct to identify any questions or concerns that the Member may have.

2. CalOptima's Case Management Department shall verify that the Member is connected to the Center for Comprehensive Care and Diagnosis of Inherited Blood Disorders, the Orange County Federal Hemophilia Treatment Center.

3. A CalOptima case manager shall:

a. Follow the Member's progress during any hospital admission and coordinate with the facility case manager to ensure that all discharge needs are met;

b. Provide ongoing communication with the Member after discharge from any hospital admission, as the severity and complexity of the case requires, to identify any issues and to assist in coordinating follow-up care;

c. Continue to coordinate with the Federal Hemophilia Treatment Center and provide authorizations as needed for follow-up care; and

d. Close the case according to case closure criteria.

IV. ATTACHMENT(S)

Not Applicable

DRAFT_20191003BOD_Concurrent DHCS Review

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V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct

VI. REGULATORY AGENCY APPROVAL(S)

A. 03/29/16: Department of Health Care Services
B. 04/14/14: Department of Health Care Services
C. 03/10/14: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	01/01/2006	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	01/01/2014	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	01/01/2016	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	03/01/2017	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	04/01/2018	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	10/03/2019	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal

DRAFT_20191003BOD_Concurrent DHCS Review

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IX. GLOSSARY

Term	Definition
340B Drug Pricing Program	Program established pursuant to section 340B of the Public Health Service Act, which limits the cost of covered outpatient drugs to covered entities as defined by 340B(a)(4) of the Public Health Service Act.
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.
Care Management and Coordination	A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.
Contract	The written instrument between CalOptima and physicians, hospitals, health maintenance organizations (HMOs), or other entities. Contract shall include any Memorandum of Understanding entered into by CalOptima that are binding on the Health Network in which a physician participates, the Department of Health Care Services (DHCS) Medi-Cal Managed Care Policy Division Policy Letters, Contract Interpretations, 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.
Federal Hemophilia Treatment Center	A provider that is part of a regional network of comprehensive hemophilia diagnostic treatment centers established and contracted through the Special Projects of Regional and National Significance (SPRANS) under 42 U.S.C., Section 701(a)(2).
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.
Hemophilia	Hemophilia A, B, C, or Von Willebrand disease. Hemophilia does not include any other acquired factor deficiencies including, but not limited to, defibrination syndrome, acquired coagulation factor deficiency, and hemorrhagic disorder due to intrinsic circulating anticoagulants.
Kaiser Member	A Member who is enrolled in, or receives all Covered Services, from Kaiser Health Foundation, Incorporated.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration, who is enrolled in a CalOptima program.

DRAFT_20191003_BOD_Current DHCS Review

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Policy #:	GG.1318
Title:	**Coordination of Care for Hemophilia Members**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2006
Revised Date:	10/03/2019

DRAFT_20191003BOD_Concurrent DHCS Review

I. PURPOSE

This policy defines the case management guidelines for coordination of care by CalOptima and its Health Networks for Members diagnosed with Hemophilia.

II. POLICY

A. This policy shall apply to Medi-Cal Members age twenty-one (21) and over, until implementation of the Whole-Child Model program, at which time it shall apply to Medi-Cal Members of any age.

B. CalOptima is responsible for providing case management to a CalOptima Direct Member who is diagnosed with Hemophilia, in accordance with the provisions of this policy.

C. If a Health Network Member, except a Kaiser Member, is diagnosed with Hemophilia, CalOptima shall transition such Member to CalOptima Direct, in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.

D. A CalOptima Direct Member who is diagnosed with Hemophilia shall receive care from a Federal Hemophilia Treatment Center, in accordance with the provisions of this policy.

E. A CalOptima Direct Member who is diagnosed with Hemophilia shall receive Hemophilia factor from a Pharmacy that is registered as a covered entity in the 340B Drug Pricing Program.

III. PROCEDURE

A. A Provider is responsible for diagnosing a Member with Hemophilia.

B. Upon receipt of notice of a Member who is diagnosed with Hemophilia, a Health Network (except Kaiser Health Foundation) shall:

1. Notify CalOptima's Case Management Department via secure email within five (5) business days after identification of such Member; and

2. Provide Case Management to the Member until the Member is effectively transitioned to CalOptima Direct.

C. Upon receipt of a written notice from a Health Network as set forth in Section III.B of this policy:

1. CalOptima's Case Management Department shall open a case for oversight until the Member transitions to CalOptima Direct;

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2. CalOptima's Case Manager shall submit a Change of Network Request (CONR) to CalOptima's Medi-Cal Enrollment and Reconciliation Department inbox to request Health Network assignment to CalOptima Direct (COD);

3. CalOptima's Medi-Cal Enrollment and Reconciliation Department shall transition the Member to CalOptima Direct as set forth in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct; and

4. CalOptima shall notify the Member of the transition to CalOptima Direct within five (5) business days after receipt of notice from the Health Network.

D. CalOptima shall provide case management and care coordination to a Member who is not a Kaiser Member and is diagnosed with Hemophilia as follows:

1. CalOptima's Case Management Department shall contact the Member by telephone within (10) business days after transition to CalOptima Direct to identify any questions or concerns that the Member may have.

2. CalOptima's Case Management Department shall verify that the Member is connected to the Center for Comprehensive Care and Diagnosis of Inherited Blood Disorders, the Orange County Federal Hemophilia Treatment Center.

3. A CalOptima case manager shall:

a. Follow the Member's progress during any hospital admission and coordinate with the facility case manager to ensure that all discharge needs are met;

b. Provide ongoing communication with the Member after discharge from any hospital admission, as the severity and complexity of the case requires, to identify any issues and to assist in coordinating follow-up care;

c. Continue to coordinate with the Federal Hemophilia Treatment Center and provide authorizations as needed for follow-up care; and

d. Close the case according to case closure criteria.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct

VI. REGULATORY AGENCY APPROVAL(S)

A. 03/29/16: Department of Health Care Services
B. 04/14/14: Department of Health Care Services
C. 03/10/14: Department of Health Care Services

DRAFT_20191003_DD_Concurrent DHCS Review

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VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2006	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	01/01/2014	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	01/01/2016	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	03/01/2017	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	04/01/2018	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	10/03/2019	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal

DRAFT_20191003BOD_Contained DHCS Review

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IX. GLOSSARY

Term	Definition
340B Drug Pricing Program	Program established pursuant to section 340B of the Public Health Service Act, which limits the cost of covered outpatient drugs to covered entities as defined by 340B(a)(4) of the Public Health Service Act.
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.
Care Management and Coordination	A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.
Contract	The written instrument between CalOptima and physicians, hospitals, health maintenance organizations (HMOs), or other entities. Contract shall include any Memorandum of Understanding entered into by CalOptima that are binding on the Health Network in which a physician participates, the Department of Health Care Services (DHCS) Medi-Cal Managed Care Policy Division Policy Letters, Contract Interpretations, 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.
Federal Hemophilia Treatment Center	A provider that is part of a regional network of comprehensive hemophilia diagnostic treatment centers established and contracted through the Special Projects of Regional and National Significance (SPRANS) under 42 U.S.C., Section 701(a)(2).
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.
Hemophilia	Hemophilia A, B, C, or Von Willebrand disease. Hemophilia does not include any other acquired factor deficiencies including, but not limited to, defibrination syndrome, acquired coagulation factor deficiency, and hemorrhagic disorder due to intrinsic circulating anticoagulants.
Kaiser Member	A Member who is enrolled in, or receives all Covered Services, from Kaiser Health Foundation, Incorporated.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration, who is enrolled in a CalOptima program.

DRAFT_20191003_POLC required DHCS review

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Policy #:	GG.1539
Title:	**Authorization for Out-of-Network and Out-of-Area Services**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/2015
~~Last Review Date:~~	~~08/01/18~~
~~Last~~ Revised Date:	~~08/01/18~~10/03/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes ~~CalOptima's~~ requirements and process for authorization of **Out-of-Network** and **Out-of-Area Covered Services**~~.~~ for **Members** assigned to **CalOptima Direct** or a **Health Network**.

II. POLICY

A. If CalOptima delegates Utilization Management ~~(UM)~~ activities to a **Health Network**, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation, the **Health Network** shall be responsible~~, subject to CalOptima's approval,~~ for authorization determinations for **Member** referrals for **Covered Services**:

1. **Out-of-Network**~~;~~ for Medi-Cal, OneCare Connect, and~~-~~/or OneCare, as applicable; and

2. **Out-of-Area**, as directed by the **Health Network**~~.~~ ~~–~~, for Medi-Cal, OneCare Connect, and/or One Care, as applicable.

B. CalOptima or a **Health Network** may authorize **Out-of-Network** and **Out-of-Area Covered Services**, as applicable, if a **Member**, due to his or her medical condition, requires:

1. **Covered Services** from a **Non-Contracted Provider**;

2. Specialty care that is not available within the network; and/or

~~2.~~3. Tertiary ~~Facility~~facility specialty care that is not available within the network~~;~~.

~~3. Specialty care that is not available within the network;~~

~~4. Continuity of Care~~ CalOptima or a **Health Network** shall process requests for ~~special medical needs, such as End-Stage Renal Disease (ESRD), while traveling;~~

~~5. Urgent Care Service, while traveling; and~~

~~6. Emergency Services from a Non-Contracted Provider.~~

~~C. CalOptima may deny any request for post-service authorization of~~ **Covered Services** ~~provided to a Member Out-of-Network, or Out-of-Area, based on lack of documentation of Medical Necessity, or failure to meet criteria outlined in Section II.B. of this policy.~~

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~~D. A Member shall notify his or her Primary Care Physician (PCP) within seventy-two (72) hours after accessing Out-of-Network, or Out-of-Area, Emergency Services.~~

~~E.~~A. ~~CalOptima or a **Health Network** shall ensure **Continuity of Care** for a **Member** transitioning from traditional Fee-For-Service (FFS), another Managed Care Plan, or California Children's Services (CCS) program into the Whole Child Model (WCM) program, with his or her out-of-network nursing facility, Primary Care Physician (PCP), or Specialty Care Provider,~~ in accordance with CalOptima ~~Policies GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima, MA.6021a: Continuity of Care for New Members, and CMC.6021a: Continuity of Care for New Members.~~

~~III. PROCEDURE~~

~~F.~~C. ~~When requesting an authorization, a Provider or Practitioner, including Specialty Practitioners, shall adhere to the responsibilities outlined in CalOptima~~ Policy GG.~~1113: Specialty Practitioner Responsibilities.~~1508: Authorization and Processing of Referrals.

~~G.~~D. ~~CalOptima's Utilization Management Department~~CalOptima or a **Health Network** shall review all requests and notices for ~~Out-of-Area~~ **Covered Services** for a **Member** utilizing criteria described in CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines.

E. CalOptima or a **Health Network** shall ~~process requests~~ensure that **Members** eligible with the Whole-Child Model (WCM) program are provided accurate information on how to request and seek approval for **Out-of-Network Covered Services**~~, in accordance with CalOptima Policy~~.

~~H.~~F. **Covered Services** not subject to prior authorization are set forth in CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

G. CalOptima or a **Health Network** shall review any request for post-service authorization of **Covered Services** provided to a **Member** when submitted in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

H. CalOptima or a **Health Network** shall ensure **Continuity of Care** for a **Member** transitioning from traditional Fee-For-Service (FFS), another Medi-Cal Managed Care Plan, or **California Children's Services (CCS)** program into the **WCM** program, in accordance with CalOptima Policies GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima Services, MA.6021a: Continuity of Care for New Members, and CMC.6021a: Continuity of Care for New Members, and GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program.

III. PROCEDURE ~~services that do not require a Prior Authorization,~~

A. For **Covered Services**, network **Providers**, including **Specialty Care Practitioners**, shall refer the **Member** to ~~a~~ another network **Provider** (contracted **Provider**~~,~~), unless ~~such~~ a **Provider** of the required type is unavailable in-network. Referrals to an ~~out~~Orange County **Out-of-**~~network~~**Network Provider** shall be processed in accordance with Section III.C of this

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Policy.policy. Referrals to an **Out-of-Area Provider** shall be processed in accordance with Section III.B of this policy.

1. For **Sensitive Services**, **Members** may access any **Provider**, including those who are outOut-of-networkNetwork, as outlined in CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.

B. Authorization for **Out-of-**Network services**Area Covered Services**:

1. For OneCare Connect and Medi-Cal only, upon determination that a **Member** requires **Out-of-Area Covered Services** Out-of-Area, the referring **Practitioner** shall request authorization from the Member's **Health Network**.
, or CalOptima
1. For OneCare, a Member's Health Network shall notify the CalOptima Utilization Management Department within one (1) working day after identifying the Member's need for Out-of-Network Covered Services.

a. A Member's Health Network shall notify the **CalOptima** Utilization Management Department within twenty-four (24) hours after the Health Network receives notice of a OneCare Member's admission to an Out-of-Network acute care facility.

B. **Direct Members,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for Out-of-Area Covered Services;
CalOptima Direct
1. For OneCare Connect and Medi-Cal only, upon determination that a Member requires Covered Services Out-of-Area, the referring Practitioner shall request authorization from the Member's Health NetworkCalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

a. Upon notice of a **Member's** acute admission to an Out-of-Area facility, the Member's **Health Network**, or CalOptima's case management nurse for **CalOptima Direct Members**, shall conduct concurrent review by telephone until the **Member** is discharged.

b. Prior to a **Member's** discharge from an **Out-of-Area** facility, the Member's **Health Network**, or CalOptima Utilization Management Department for **CalOptima Direct Members**, shall be responsible for ensuring the provision of a **Member's** medical needs, supports, and services throughout the post-discharge and transition to community-based care period by:

i. Performing appropriate discharge planning; and

ii. Coordinating post-hospitalization services, as needed.

2. For OneCare, upon determination that a **Member** requires **Out-of-Area Covered Services** Out-of-Area, the referring **Practitioner** shall request authorization from CalOptima's Utilization Management (UM) Department, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

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a. If a Member's **Health Network** receives notification of a **Member's** admission to an **Out-of-Area** facility for **Covered Services**, the **Health Network** shall notify the CalOptima Utilization Management Department within twenty-four (24) hours.

b. Upon notice of a Member's acute admission to an **Out-of-Area** facility, a CalOptima case management nurse shall conduct concurrent review ~~by telephone~~ until the **Member** is discharged in accordance with CalOptima Policy GG.1501: Inpatient Length of Stay Assignment~~.~~.

c. Prior to a Member's discharge from an **Out-of-Area** facility, the CalOptima Utilization Management ~~(UM)~~ Department and the Member's **Health Network** shall ~~be responsible for ensuring~~coordinate the provision of a **Member's** medical needs, supports, and services throughout the post-discharge and transition to community-based care period by:

i. Performing appropriate discharge planning; and

ii. Coordinating post-hospitalization services, as needed.

C. Authorization for **Out-of-Network Covered Services**

1. For Medi-Cal, One Care, and OneCare Connect, upon determination that a **Member** requires **Covered Services Out-of-Network**, the referring **Practitioner** shall request authorization from the **Member's Health Network**, or CalOptima for **CalOptima Direct Members,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, GG.1508: Authorization and Processing of Referrals, and GG.1501: Inpatient Length of Stay Assignment.

a. Upon notice of a **Member's** acute admission to an **Out-of-Network** facility, the **Member's Health Network**, or CalOptima for **CalOptima Direct Members**, shall conduct concurrent review until the **Member** is discharged.

b. Prior to a **Member's** discharge from an **Out-of-Network** facility, the Member's **Health Network** or CalOptima, for **CalOptima Direct Members**, shall be responsible for ensuring the provision of a **Member's Covered Services** throughout the post-discharge and transition to community-based care period, by:

i. Performing appropriate discharge planning; and

ii. Coordinating post-hospitalization services, as needed.

2. Whole-Child Model Program

a. For the **WCM** program, **CCS-eligible Members** and **CCS**-paneled **Providers** shall follow CalOptima or **Health Network's** authorization policies and procedure to obtain appropriate approvals prior to accessing an **Out-of-Network CCS Provider**;

b. CalOptima or a **Health Network** shall allow **CCS**-eligible **Members** access to **Out-of-Network CCS Providers** in order to obtain **Medically Necessary Covered Services** related to the **Members' CCS-eligible Condition**, if:

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i. CalOptima or a **Health Network** has no specialist that treats the **CCS-Eligible Condition** within the network;

ii. In-network **Providers** are unable to meet timely access standards, as described in CalOptima Policy GG.1600: Access and Availability Standards; or

iii. **WCM Continuity of Care** requirements are applicable to the **WCM Member** at the time the service is provided, as outlined in CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

c. CalOptima or a **Health Network** cannot deny **Out-of-Network Covered Services** based upon cost or location.

d. CalOptima or a **Health Network** shall ensure transportation is provided for **CCS**-eligible **Members** obtaining **Out-of-Network Covered Services** in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

IV. ATTACHMENTS

A. CalOptima Authorization Request Form (ARF)

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 Health Network Service Agreement
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy CMC.1001: Glossary of Terms
G. CalOptima Policy CMC.6021a: Continuity of Care for New Members
H. CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program
~~H.~~I. CalOptima Policy GG.1113 Specialty Practitioner Responsibilities
~~I.~~J. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network
~~J.~~K. CalOptima Policy GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima
L. CalOptima Policy GG.1500 Authorization and Processing of Referrals
M. CalOptima Policy GG.1501: Inpatient Length of Stay Assignment
~~K.~~N. CalOptima Policy GG.1505: Transportation Emergency, Non-Emergency, and Non-Medical
~~L.~~O. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~M.~~P. CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines
~~N.~~Q. CalOptima Policy GG.1541: Utilization Management Delegation
R. CalOptima Policy GG.1547: Maintenance and Transportation
S. CalOptima Policy GG.1600: Access and Availability Standards
~~O.~~T. CalOptima Policy MA.1001: Glossary of Terms

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~~P.~~U. CalOptima Policy MA.6021a: Continuity of Care for New Members
V. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	10/01/2005	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	09/01/2008	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	11/01/2015	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	06/01/2017	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	08/01/2018	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	10/03/2019	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect

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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 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.
California Children's Services (CCS) Provider	Include any of the following: (1) A medical provider that is paneled by the CCS program to treat a CCS-Eligible Condition, pursuant to Article 5 of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code (commencing with Section 123800); (2) A licensed acute care hospital approved by the CCS program to treat a CCS-Eligible Condition; or (3) A special care center approved by the CCS program to treat a CCS-Eligible Condition.
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 a pre-existing Provider relationship.
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~~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).

Term	Definition
Emergency Service	Those covered inpatient and outpatient services required that are 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), a ~~hysician~~ physician 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~~covered services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	An enrollee-beneficiary of a CalOptima program.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Out-of-Area	Covered ~~services~~Services provided outside the County of Orange by an appropriate~~,~~ Qualified Health Care Professional.
Out-of-Network	Covered ~~services~~Services provided by a non-contracted~~,~~ and appropriate~~,~~ Qualified Health Care Professional ~~qualified health care professional~~.
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.

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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, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
Provider	For purposes of this policy, a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or entity that furnished Covered Services and is licensed or certified to do so.
Qualified Health Care Professional	A Primary Care Physician (PCP), specialist, or other licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, or condition.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialty Care Provider or Specialty Care Practitioner	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Policy #:	GG.1539
Title:	**Authorization for Out-of-Network and Out-of-Area Services**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/2015
Revised Date:	10/03/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes requirements and process for authorization of **Out-of-Network** and **Out-of-Area Covered Services** for **Members** assigned to **CalOptima Direct** or a **Health Network**.

II. POLICY

A. If CalOptima delegates Utilization Management activities to a **Health Network**, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation, the **Health Network** shall be responsible for authorization determinations for **Member** referrals for **Covered Services**:

1. **Out-of-Network** for Medi-Cal, OneCare Connect, and/or OneCare, as applicable; and

2. **Out-of-Area**, as directed by the **Health Network**, for Medi-Cal, OneCare Connect, and/or One Care, as applicable.

B. CalOptima or a **Health Network** may authorize **Out-of-Network** and **Out-of-Area Covered Services**, as applicable, if a **Member**, due to his or her medical condition, requires:

1. **Covered Services** from a **Non-Contracted Provider**;

2. Specialty care that is not available within the network; and/or

3. Tertiary facility specialty care that is not available within the network.

C. CalOptima or a **Health Network** shall process requests for **Covered Services** in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

D. CalOptima or a **Health Network** shall review all requests and notices for **Covered Services** for a **Member** utilizing criteria described in CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines.

E. CalOptima or a **Health Network** shall ensure that **Members** eligible with the Whole-Child Model (WCM) program are provided accurate information on how to request and seek approval for **Out-of-Network Covered Services**.

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F. **Covered Services** not subject to prior authorization are set forth in CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

G. CalOptima or a **Health Network** shall review any request for post-service authorization of **Covered Services** provided to a **Member** when submitted in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

H. CalOptima or a **Health Network** shall ensure **Continuity of Care** for a **Member** transitioning from traditional Fee-For-Service (FFS), another Medi-Cal Managed Care Plan, or **California Children's Services (CCS)** program into the **WCM** program, in accordance with CalOptima Policies GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima Services, MA.6021a: Continuity of Care for New Members, and CMC.6021a: Continuity of Care for New Members, and GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program.

III. PROCEDURE

A. For **Covered Services**, network **Providers**, including **Specialty Care Practitioners**, shall refer the **Member** to another network **Provider** (contracted **Provider**), unless a **Provider** of the required type is unavailable in-network. Referrals to an Orange County **Out-of-Network Provider** shall be processed in accordance with Section III.C of this policy. Referrals to an **Out-of-Area Provider** shall be processed in accordance with Section III.B of this policy.

1. For **Sensitive Services**, **Members** may access any **Provider**, including those who are **Out-of-Network**, as outlined in CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.

B. Authorization for **Out-of-Area Covered Services**:

1. For OneCare Connect and Medi-Cal only, upon determination that a **Member** requires **Out-of-Area Covered Services**, the referring **Practitioner** shall request authorization from the Member's **Health Network**, or CalOptima for **CalOptima Direct Members,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

    a. Upon notice of a **Member's** acute admission to an Out-of-Area facility, the Member's**Health Network,** or CalOptima's case management nurse for **CalOptima Direct Members**, shall conduct concurrent review until the **Member** is discharged.

    b. Prior to a **Member's** discharge from an **Out-of-Area** facility, the Member's **Health Network**, or CalOptima Utilization Management Department for **CalOptima Direct Members**, shall be responsible for ensuring the provision of a **Member's** medical needs, supports, and services throughout the post-discharge and transition to community-based care period by:

        i. Performing appropriate discharge planning; and

        ii. Coordinating post-hospitalization services, as needed.

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2. For OneCare, upon determination that a **Member** requires **Out-of-Area Covered Services**, the referring **Practitioner** shall request authorization from CalOptima's Utilization Management Department in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

    a. If a Member's **Health Network** receives notification of a **Member's** admission to an **Out-of-Area** facility for **Covered Services**, the **Health Network** shall notify the CalOptima Utilization Management Department within twenty-four (24) hours.

    b. Upon notice of a Member's acute admission to an **Out-of-Area** facility, a CalOptima case management nurse shall conduct concurrent review until the **Member** is discharged in accordance with CalOptima Policy GG.1501: Inpatient Length of Stay Assignment.

    c. Prior to a Member's discharge from an **Out-of-Area** facility, the CalOptima Utilization Management Department and the Member's **Health Network** shall coordinate the provision of a **Member's** medical needs, supports, and services throughout the post-discharge and transition to community-based care period by:

        i. Performing appropriate discharge planning; and

        ii. Coordinating post-hospitalization services, as needed.

C. Authorization for **Out-of-Network Covered Services**

1. For Medi-Cal, One Care, and OneCare Connect, upon determination that a **Member** requires **Covered Services Out-of-Network**, the referring **Practitioner** shall request authorization from the **Member's Health Network**, or CalOptima for **CalOptima Direct Members,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, GG.1508: Authorization and Processing of Referrals, and GG.1501: Inpatient Length of Stay Assignment.

    a. Upon notice of a **Member's** acute admission to an **Out-of-Network** facility, the **Member's Health Network**, or CalOptima for **CalOptima Direct Members**, shall conduct concurrent review until the **Member** is discharged.

    b. Prior to a **Member's** discharge from an **Out-of-Network** facility, the Member's **Health Network** or CalOptima, for **CalOptima Direct Members**, shall be responsible for ensuring the provision of a **Member's Covered Services** throughout the post-discharge and transition to community-based care period, by:

        i. Performing appropriate discharge planning; and

        ii. Coordinating post-hospitalization services, as needed.

2. Whole-Child Model Program

    a. For the **WCM** program, **CCS-eligible Members** and **CCS**-paneled **Providers** shall follow CalOptima or **Health Network's** authorization policies and procedure to obtain appropriate approvals prior to accessing an **Out-of-Network CCS Provider**;

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b. CalOptima or a **Health Network** shall allow **CCS**-eligible **Members** access to **Out-of-Network CCS Providers** in order to obtain **Medically Necessary Covered Services** related to the **Members' CCS-eligible Condition**, if:

i. CalOptima or a **Health Network** has no specialist that treats the **CCS-Eligible Condition** within the network;

ii. In-network **Providers** are unable to meet timely access standards, as described in CalOptima Policy GG.1600: Access and Availability Standards; or

iii. **WCM Continuity of Care** requirements are applicable to the **WCM Member** at the time the service is provided, as outlined in CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

c. CalOptima or a **Health Network** cannot deny **Out-of-Network Covered Services** based upon cost or location.

d. CalOptima or a **Health Network** shall ensure transportation is provided for **CCS**-eligible **Members** obtaining **Out-of-Network Covered Services** in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

IV. ATTACHMENTS

A. CalOptima Authorization Request Form (ARF)

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 Health Network Service Agreement
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy CMC.1001: Glossary of Terms
G. CalOptima Policy CMC.6021a: Continuity of Care for New Members
H. CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program
I. CalOptima Policy GG.1113 Specialty Practitioner Responsibilities
J. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network
K. CalOptima Policy GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima
L. CalOptima Policy GG.1500 Authorization and Processing of Referrals
M. CalOptima Policy GG.1501: Inpatient Length of Stay Assignment
N. CalOptima Policy GG.1505: Transportation Emergency, Non-Emergency, and Non-Medical
O. CalOptima Policy GG.1508: Authorization and Processing of Referrals
P. CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines
Q. CalOptima Policy GG.1541: Utilization Management Delegation
R. CalOptima Policy GG.1547: Maintenance and Transportation
S. CalOptima Policy GG.1600: Access and Availability Standards
T. CalOptima Policy MA.1001: Glossary of Terms

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U. CalOptima Policy MA.6021a: Continuity of Care for New Members
V. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2005	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	09/01/2008	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	11/01/2015	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	06/01/2017	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	08/01/2018	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	10/03/2019	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect

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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 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.
California Children's Services (CCS) Provider	Include any of the following: (1) A medical provider that is paneled by the CCS program to treat a CCS-Eligible Condition, pursuant to Article 5 of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code (commencing with Section 123800); (2) A licensed acute care hospital approved by the CCS program to treat a CCS-Eligible Condition; or (3) A special care center approved by the CCS program to treat a CCS-Eligible Condition.
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 a pre-existing Provider relationship.
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).
Emergency Service	Those covered inpatient and outpatient services required that are 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), a physician under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	An enrollee-beneficiary of a CalOptima program.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Out-of-Area	Covered Services provided outside the County of Orange by an appropriate Qualified Health Care Professional.
Out-of-Network	Covered Services provided by a non-contracted and appropriate Qualified Health Care Professional.
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, "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).

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Term	Definition
Provider	For purposes of this policy, a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or entity that furnished Covered Services and is licensed or certified to do so.
Qualified Health Care Professional	A Primary Care Physician (PCP), specialist, or other licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, or condition.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialty Care Provider or Specialty Care Practitioner	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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CalOptima
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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

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Policy ~~#:~~:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	08/01/2005
Revised Date:	~~04/01/2019~~10/03/2019
Applicable to:	☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima or a **Health Network*** in accordance with applicable statutory~~-~~, and regulatory ~~guidelines~~requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima or a Health Network shall reimburse a claim for **Covered Services*** rendered to a **Member** in accordance with the standard allowances set by CalOptima ~~fee schedules~~Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted **Provider**.

B. A **Provider** shall submit a claim for **Covered Services** rendered on, or after, January 1, 2010 as follows:

1. A **Non-Contracted Provider** shall submit a claim for **Covered Services** rendered to a **Member** within one (1) calendar year after the date of service.

2. A contracted **Provider** shall submit a claim for **Covered Services** rendered to a **Member** within the time frame specified in the contracted **Provider** agreement. If the contracted Provider agreement does not specify a time frame, the contracted **Provider** shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima or a **Health Network** shall make timely and reasonable payment for the following **Covered Services** provided to a **Member** by a **Non-Contracted Provider**:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the **Member's** health, as provided in CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. **Emergency Services** - Emergency medical services *do not* require **Prior Authorization**. If ~~no~~it is determined that the Member is to be admitted and CalOptima or a Health Network does not have a notification of ~~ER admission~~an inpatient admission from the ER ~~is~~ on file for the room and board charges, ~~the examiner~~CalOptima or a **Health Network** must~~-~~ pay the emergency triage fee and request **Medical Records**;

3. Urgently needed services;

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

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4. ~~Post~~Authorized post-stabilization care services;

5. Renal dialysis services when the **Member** is temporarily out-of-area and cannot reasonably access a contracted **Provider** for such **Covered Services**;

6. Denied **Covered Services** ~~denied which~~that are ~~found~~determined in the **Appeal** processes ~~as described~~ in CalOptima ~~Policies CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, CMC.9005: Payment Appeal, MA.9003: Standard Appeal, MA.9004: Expedited Appeal, and MA.9005: Payment Appeal,~~policies to be services the **Member** was entitled to have furnished, or paid for, by CalOptima or a **Health Network**; and

~~7. Specialty care provided outside of the network, but at in-network cost-sharing, in order to satisfy all Medicare Part A and Part B benefits. That is, if a **Member** requires a very specialized **Covered Service** that is not provided by the physicians in the network,~~ CalOptima or a Health Network shall ~~arrange for that service to be provided by a qualified **Non-Contracted**~~provide Medically Necessary, Covered Services to a Member through an out-of-network Provider~~.~~

~~D.~~ when CalOptima ~~may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims.~~ or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima ~~may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.~~

7. Policy EE.1141Δ: CalOptima Provider Contracts.

~~E.~~D. CalOptima or a **Health Network** shall pay, or deny, a claim as follows:

1. Contracted **Providers**

   a. CalOptima or a Health Network shall pay, or deny, a claim from a contracted **Provider**, or portion thereof, in accordance with the ~~time frames specified in~~timeframes, terms, and conditions of the ~~contracted~~ Provider ~~agreement.~~ Agreement.

2. **Non-Contracted Providers**

   a. CalOptima or a Health Network shall pay, or deny, ninety-five percent (95%) of all **Clean Claim**s from **Non-Contracted Providers** within thirty (30) calendar days after the date of receipt.

   b. CalOptima or a Health Network shall pay, or deny, all other claims from **Non-Contracted Providers** within sixty (60) calendar days after the date of receipt.

   c. If CalOptima or a Health Network fails to pay a **Clean Claim** from a **Non-Contracted Provider** within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

   d. CalOptima or a Health Network shall reimburse a **Non-Contracted Provider** at the Medicare Fee Schedule for Medicare Part B professional services.

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e. For Dates of Service effective beginning January 1, 2019, CalOptima or a Health Network shall administer the **Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS)** for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by **CMS** in the MIPS adjustment data files.

i. CalOptima or a Health Network may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retroactive adjustment to paid claims.

ii. CalOptima or a Health Network are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

~~F.~~E. If CalOptima or a **Health Network** denies payment of a **Clean Claim**, CalOptima or a Health Network shall notify the **Member** with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

   a. The specific reasons for the payment denial;

   b. Inform the **Member** of his or her right to request an **Appeal**;

   c. Describe the **Appeal**s process, time frames, and other elements; and

   d. Inform the **Member** of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered ~~by CalOptima,~~under the Medicare program, **,** but is covered by and payable under a **Member's** Medi-Cal coverage, CalOptima or a **Health Network** shall not send the **Member** a Notice of Denial of Payment.

~~G.~~F. The CalOptima Claims Administration Department or a **Health Network** shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

~~H.~~G. CalOptima or a **Health Network** shall identify payers that are primary to Medicare, shall determine the amounts payable ~~to~~by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

~~I.~~H. **Provider** Appeal and Grievance

1. A **Provider** may **Appeal** a claim determination in accordance with CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

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2. A **Provider** may file a **Grievance** in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

III. PROCEDURE

A. If CalOptima or a **Health Network** receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) working days after the date of receipt, as applicable.

B. **Invalid/Incomplete Claims**

1. If CalOptima or a Health Network receives an Invalid, or Incomplete, Claim, it shall notify the **Provider** no later than ten (10) working days after the date of receipt, in writing, with a request for the missing, or invalid, information.

2. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima's notice, ~~CalOptima~~CalOptima's or a **Health Network** notice, CalOptima or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima or a Health Network denies an **Invalid/Incomplete Claim**, the **Provider** shall have no rights to **Appeal** such denial.

C. **Non-Clean Claims**

1. If CalOptima or a **Health Network** receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima or a **Health Network** shall notify a **Provider** of a **Non-Clean Claim** no later than thirty (30) working days after the date of receipt, in writing, with a request for the missing information. If CalOptima or a **Health Network** requests reasonably relevant information from a **Provider** in addition to information that the **Provider** submits with a claim, CalOptima or a **Health Network** shall provide a written explanation of the necessity for such request.

3. Contracted/**Non-Contracted Providers**:

a. If CalOptima or a **Health Network** does not receive the requested information within forty-five (45) calendar days after it receives the claim, ~~the claim examiner~~CalOptima or a **Health Network** shall- send a second (2nd) letter to the contracted/**Non-Contracted Provider** requesting such information.

b. If CalOptima or a **Health Network** does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima or a **Health Network** shall review the claim with the information available and shall make a determination to pay, or deny, the claim.

4. ~~The claims processor~~ CalOptima or a **Health Network** shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

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5. If CalOptima or a **Health Network** denies a claim based on a **Provider's** failure to provide requested **Medical Record**s or other information, it shall process any dispute arising from the denial of such claim as a **Provider Grievance**, in accordance with Section II.I. of this Policy.

6. If CalOptima or a **Health Network** denies a claim based on a **Provider's** failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the **Provider's** submission of a **Grievance** in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima or a **Health Network** shall have the right to accept and adjudicate the claim.

2. CalOptima or a **Health Network** may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima or a **Health Network** may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. Record Maintenance

1. CalOptima or a **Health Networks** shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a **Clean Claim**, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima or a **Health Networks** took such action, in the same manner that the **Provider** submitted the claim.

2. CalOptima or a **Health Networks** shall maintain all **Member Medical Record**s and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare Integrated Denial Notice CMS 10003-NDMCP; OMB Approval 0938-0829 (Expires: 01/31/2020) H5433_UM17_3a (Rev 8/30/17)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~B.~~C. CalOptima PACE Program Agreement
~~C.~~D. CalOptima Policy CMC.3103: Claims Coordination of Benefits
~~D.~~E. CalOptima Policy CMC.9003: Standard Appeal
~~E.~~F. CalOptima Policy CMC.9004: Expedited Appeal
~~F.~~G. CalOptima Policy CMC.9005: Payment Appeal
H. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
~~G.~~I. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
~~H.~~J. CalOptima Policy MA.3103: Coordination of Benefits
~~I.~~K. CalOptima Policy MA.9003: Standard Appeal
~~J.~~L. CalOptima Policy MA.9004: Expedited Appeal
~~K.~~M. CalOptima Policy MA.9005: Payment Appeal

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~~L.~~N. CalOptima Policy MA.9006: Provider Complaint Process

~~M.~~A. ~~CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~

~~N.~~O. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections

~~O.~~P. Medicare Managed Care Manual, Chapter 6: Relationships with Providers

~~P.~~Q. Patient Protection and Affordable Care Act, §6404

~~Q.~~R. Title 31, United States Code (U.S.C.), §3902(a)

~~R.~~S. Title 42, Code of Federal Regulations (C.F.R.), §410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), ~~and~~ 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.

Term	Definition
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.

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Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	08/01/2005
Revised Date:	10/03/2019
Applicable to:	☒ OneCare ☒ OneCare Connect ☒ PACE

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I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima or a **Health Network*** in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima or a Health Network shall reimburse a claim for **Covered Services** rendered to a **Member** in accordance with the standard allowances set by CalOptima Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted **Provider**.

B. A **Provider** shall submit a claim for **Covered Services** rendered on, or after, January 1, 2010 as follows:

1. A **Non-Contracted Provider** shall submit a claim for **Covered Services** rendered to a **Member** within one (1) calendar year after the date of service.

2. A contracted **Provider** shall submit a claim for **Covered Services** rendered to a **Member** within the time frame specified in the contracted **Provider** agreement. If the contracted Provider agreement does not specify a time frame, the contracted **Provider** shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima or a **Health Network** shall make timely and reasonable payment for the following **Covered Services** provided to a **Member** by a **Non-Contracted Provider**:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the **Member's** health, as provided in CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. **Emergency Services** - Emergency medical services *do not* require **Prior Authorization**. If it is determined that the Member is to be admitted and CalOptima or a Health Network does not have a notification of an inpatient admission from the ER on file for the room and board charges, CalOptima or a **Health Network** must pay the emergency triage fee and request **Medical Records**;

3. Urgently needed services;

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

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4. Authorized post-stabilization care services;

5. Renal dialysis services when the **Member** is temporarily out-of-area and cannot reasonably access a contracted **Provider** for such **Covered Services**;

6. Denied **Covered Services** that are determined in the **Appeal** processes in CalOptima policies to be services the **Member** was entitled to have furnished, or paid for, by CalOptima or a **Health Network**; and

7. CalOptima or a Health Network shall provide Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Policy EE.1141Δ: CalOptima Provider Contracts.

D. CalOptima or a **Health Network** shall pay, or deny, a claim as follows:

1. Contracted **Providers**

a. CalOptima or a Health Network shall pay, or deny, a claim from a contracted **Provider**, or portion thereof, in accordance with the timeframes, terms, and conditions of the Provider Agreement.

2. **Non-Contracted Providers**

a. CalOptima or a Health Network shall pay, or deny, ninety-five percent (95%) of all **Clean Claim**s from **Non-Contracted Providers** within thirty (30) calendar days after the date of receipt.

b. CalOptima or a Health Network shall pay, or deny, all other claims from **Non-Contracted Providers** within sixty (60) calendar days after the date of receipt.

c. If CalOptima or a Health Network fails to pay a **Clean Claim** from a **Non-Contracted Provider** within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

d. CalOptima or a Health Network shall reimburse a **Non-Contracted Provider** at the Medicare Fee Schedule for Medicare Part B professional services.

e. For Dates of Service effective beginning January 1, 2019, CalOptima or a Health Network shall administer the **Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS)** for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by **CMS** in the MIPS adjustment data files.

i. CalOptima or a Health Network may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retroactive adjustment to paid claims.

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ii. CalOptima or a Health Network are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

E. If CalOptima or a **Health Network** denies payment of a **Clean Claim**, CalOptima or a Health Network shall notify the **Member** with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

a. The specific reasons for the payment denial;

b. Inform the **Member** of his or her right to request an **Appeal**;

c. Describe the **Appeal**s process, time frames, and other elements; and

d. Inform the **Member** of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program, **,** but is covered by and payable under a **Member's** Medi-Cal coverage, CalOptima or a **Health Network** shall not send the **Member** a Notice of Denial of Payment.

F. The CalOptima Claims Administration Department or a **Health Network** shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima or a **Health Network** shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. **Provider** Appeal and Grievance

1. A **Provider** may **Appeal** a claim determination in accordance with CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

2. A **Provider** may file a **Grievance** in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

III. PROCEDURE

A. If CalOptima or a **Health Network** receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) working days after the date of receipt, as applicable.

B. **Invalid/Incomplete Claims**

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1. If CalOptima or a Health Network receives an Invalid, or Incomplete, Claim, it shall notify the **Provider** no later than ten (10) working days after the date of receipt, in writing, with a request for the missing, or invalid, information.

2. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima's notice, CalOptima's or a **Health Network** notice, CalOptima or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima or a Health Network denies an **Invalid/Incomplete Claim**, the **Provider** shall have no rights to **Appeal** such denial.

C. **Non-Clean Claims**

1. If CalOptima or a **Health Network** receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima or a **Health Network** shall notify a **Provider** of a **Non-Clean Claim** no later than thirty (30) working days after the date of receipt, in writing, with a request for the missing information. If CalOptima or a **Health Network** requests reasonably relevant information from a **Provider** in addition to information that the **Provider** submits with a claim, CalOptima or a **Health Network** shall provide a written explanation of the necessity for such request.

3. Contracted/**Non-Contracted Providers**:

   a. If CalOptima or a **Health Network** does not receive the requested information within forty-five (45) calendar days after it receives the claim, CalOptima or a **Health Network** shall send a second (2nd) letter to the contracted/**Non-Contracted Provider** requesting such information.

   b. If CalOptima or a **Health Network** does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima or a **Health Network** shall review the claim with the information available and shall make a determination to pay, or deny, the claim.

4. CalOptima or a **Health Network** shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima or a **Health Network** denies a claim based on a **Provider's** failure to provide requested **Medical Record**s or other information, it shall process any dispute arising from the denial of such claim as a **Provider Grievance**, in accordance with Section II.I. of this Policy.

6. If CalOptima or a **Health Network** denies a claim based on a **Provider's** failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the **Provider's** submission of a **Grievance** in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima or a **Health Network** shall have the right to accept and adjudicate the claim.

2. CalOptima or a **Health Network** may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of

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professional and/or facility claims. CalOptima or a **Health Network** may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. Record Maintenance

1. CalOptima or a **Health Networks** shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a **Clean Claim**, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima or a **Health Networks** took such action, in the same manner that the **Provider** submitted the claim.

2. CalOptima or a **Health Networks** shall maintain all **Member Medical Record**s and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare Integrated Denial Notice CMS 10003-NDMCP; OMB Approval 0938-0829 (Expires: 01/31/2020) H5433_UM17_3a (Rev 8/30/17)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima PACE Program Agreement
D. CalOptima Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy CMC.9005: Payment Appeal
H. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
I. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
J. CalOptima Policy MA.3103: Coordination of Benefits
K. CalOptima Policy MA.9003: Standard Appeal
L. CalOptima Policy MA.9004: Expedited Appeal
M. CalOptima Policy MA.9005: Payment Appeal
N. CalOptima Policy MA.9006: Provider Complaint Process
O. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
P. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
Q. Patient Protection and Affordable Care Act, §6404
R. Title 31, United States Code (U.S.C.), §3902(a)
S. Title 42, Code of Federal Regulations (C.F.R.), §410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.

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Term	Definition
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.

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Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Payment

Date:

Member number:
Claim number:

Name:

Your request was denied

We've denied the payment of medical services/items listed below requested by you or your doctor [ ]:

Why did we deny your request?

We denied the payment of medical services/items listed above because:

You have the right to appeal our decision

You have the right to ask OneCare (HMO SNP) to review our decision by asking us for an appeal**.**

Appeal: Ask OneCare (HMO SNP) for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-877-412-2734 to learn how to name your representative. TTY users call 1-800-735-2929. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us.

Important Information About Your Appeal Rights

There are 2 kinds of appeals

Standard Appeal – We'll give you a written decision on a standard appeal within **30 days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 days**.

Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with OneCare (HMO SNP)

Step 1: You, your representative, or your doctor [*provider*] must ask us for an appeal *or State Fair Hearing*. Your *written* request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: Mail, fax, or deliver your appeal *or call us*.

For a Standard Appeal: Address: Attention: Grievance and Appeals Resolution Services
CalOptima
505 City Parkway West
Orange, CA 92868

Phone: 1-877-412-2734 Fax: 1-714-246-8562

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

For a Fast Appeal: Phone: 1-877-412-2734 Fax: 1-714-246-8562

What happens next?

If you ask for an appeal and we continue to deny your request for *payment of* a service, we'll send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

Get help & more information

- OneCare (HMO SNP) Toll Free: 1-877-412-2734 TTY users call: 1-800-735-2929

24 hours, 7 days a week.

- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116

Sincerely,

Claims Administration
OneCare

cc: Member File

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." You can also see Chapter 9 of the Member Handbook for information about how to make an appeal.

Notice of Denial of Payment

Date:

Member number:
Claim number:

Name:

Your request was denied

We've denied the payment of medical services/items listed below requested by you or your doctor [*provider*]:

[service] [service dates]

Why did we deny your request?

We denied the payment of medical services/items listed above because:

[Remarks]

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) to review our decision by asking us for a Level 1 Appeal (sometimes called an "internal appeal" or "plan appeal").

Level 1 Appeal with OneCare Connect: Ask OneCare Connect for a Level 1 Appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for a Level 1 Appeal with OneCare Connect" for information on how to ask for a plan level appeal.

How to keep your services while we review your case: *If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue, you must ask for an appeal within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-855-705-8823 to learn how to name your representative. TDD/TTY users call 1-800-735-2929. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

There are 2 kinds of Level 1 appeals with OneCare Connect

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**.

Fast (Expedited) Appeal *– We'll give you a decision on a fast appeal as expeditiously as your condition requires, and always within* ***72 hours*** *after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting for a decision on a standard appeal.*

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. *If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.*

How to ask for a Level 1 Appeal with OneCare Connect

Step 1: You, your representative, or your provider must ask for an appeal within **60 calendar days** of getting this notice.

Your {*written*} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal or call us.

For a Standard Appeal: Address: OneCare Connect
Attention: Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

Phone: 1-855-705-8823 TTY Users Call: 1-800-735-2929
Fax: 1-714-246-8562

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

For a Fast (Expedited) Appeal: Phone: 1-855-705-8823 TTY Users Call: 1-800-735-2929
Fax: 1-714-246-8562}

What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for {*payment of*} a service, we'll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for a State Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree.

Step 1: You or your representative must ask for a State Hearing within **120 days** of the date of this notice. Fill out the "Form to File a State Hearing" that is included with this notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TDD: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision that will explain if you have additional appeal rights.

A copy of this notice has been sent to: [*insert name*]

Get help & more information

- Call **OneCare Connect** at 1-855-705-8823, 24 hours, 7 days a week. TDD/TTY users call 1-800-735-2929. You can also visit our website at www.caloptima.org/onecareconnect.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Call the **Medicare Rights Center** at 1-888-HMO-9050.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- If this notice is about your In-Home Supportive Services (IHSS) benefits, call your **local county social services office** for help. The phone number is 1-714-825-3000 and 1-800-281-9799.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- You can also see **Chapter 9 of the Member Handbook** for information about how to make an appeal.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. You can get this information for free in other languages. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-855-705-8823 (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝
1-800-735-2929):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم
(**1-800-735-2929**: TTY الهاتف النصي/خط الاتصال لضعاف السمع) **1-855-705-8823**

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau
1-855-705-8823 (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-855-705-8823 (TTY: 1-800-735-2929)**.

CalOptima PACE
13300 Garden Grove Blvd
Garden Grove, CA 92843
(714) 468-1100
TDD/TTY: (714) 468-1063

{Date}

{Participant's Name or Representative}
{C/o Participant's Name}
{Address}

RE: Notice of Action (NOA) for Service or Payment Request

Dear Mr/s {Name}:

Your request of [insert date] for [insert brief description of requested service or payment for service]

Has been: __**Denied** __**Deferred** __**Modified** for the reason(s) indicated below:

- ❑ Is not medically necessary
- ❑ Requested services will not improve or contribute to sustaining your health
- ❑ An alternative service is provided to meet your care needs
- ❑ Did not meet authorization criteria
- ❑ Is not a benefit of the PACE Program
- ❑ Requires additional information or consult
- ❑ Requested service has potentially negative health and safety issues
- ❑ Other (please describe):_____

This decision was based on the following criteria or clinical guidelines:
_____
_____

If you do not agree with the action above, you have the right to appeal the decision. Please see the attached *"Information for Participants about the Appeals Process"* for your right to request further action. You may call your Social Worker or our Quality Assurance Department at (714) 468-1100 who will explain these processes to you. For the hearing impaired (TTY/TDD), please call (714) 468-1063.

Sincerely,

[First Initial and last name of Examiner
Claims Administration

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INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

All of us at **CalOptima PACE** share responsibility for your care and your satisfaction with the services you receive. Our appeals process is designed to enable you and/or your representative the opportunity to respond to a decision made by the Interdisciplinary Team regarding your request for a service or payment of a service. At any time you wish to file an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because an appeal has been filed. **CalOptima PACE** will continue to provide you with all the required services during the appeals process. The confidentiality of your appeal will be maintained at all times throughout and after the appeals process and information pertaining to your appeal will only be released to authorized individuals.

When **CalOptima PACE** decides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing— is called an "**appeal**." You have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process at enrollment (see your Member Enrollment Agreement Terms and Conditions) and annually after that. You will also receive this information and necessary appeals forms whenever **CalOptima PACE** denies, defers or modifies a request for a service or request for payment.

Definitions:
An **appeal** is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service, including denials, reductions or termination of services.

A **representative** is the person who is acting on your behalf or assisting you, and may include, but is not limited to, a family member, a friend, a PACE employee or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If you

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request and expedited appeal, we will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

*Note: For **CalOptima PACE** participants enrolled in Medi-Cal – **CalOptima PACE** will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.*

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and **CalOptima PACE** denies, defers or modifies the request, you may appeal the decision. A written "*Notice of Action of Service or Payment Request*" (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service request or request for payment.
2. You can make your appeal either verbally(in person or by telephone) or in writing; ask any PACE Program staff of the center you attend to help you start the process. CalOptima PACE will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review. To submit relevant facts and/or evidence in writing, please send to the address listed below. Otherwise you or your representative may submit this information in person. If more information is needed, you will be contacted by **the Quality Assurance Department** who will assist you in obtaining the missing information.
3. If you wish to make your appeal by telephone, you may contact our **Quality Assurance Department** at **714-468-1100 or our toll-free number at (855) 785-2584** to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired (TTY/TDD), please call **(714) 468-1063**.
4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

   Quality Assurance Department
   CalOptima PACE
   13300 Garden Grove Blvd
   Garden Grove, CA 92843

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a standard appeal. For and expedited appeal, we will notify you or your representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received.

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6. The reconsideration of **CalOptima PACE** decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will insure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon **CalOptima PACE** completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, **CalOptima PACE** will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on your Appeal:
If we decide fully in your favor on a **standard appeal** for a request for ***service***, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. **If we decide in your favor** on a request for ***payment***, we are required to make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide fully in your favor on a **standard appeal** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see **Additional Appeal Rights,** below). We also are required to notify you as soon as we make a decision and also to notify the federal Center for Medicare and Medicaid Services and the Department of Health Care Services. We will inform you in writing of your **external** appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which external program to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

If we decide fully in your favor on an **expedited appeal** we are required to get the service or give you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an appeal.

If we do not decide in your favor on an **expedited appeal** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (**see Additional Appeal Rights**). We are required to notify you as soon as we make a decision and also to notify the Center for Medicare and Medicaid Services and the Department of Health Care Services. We let you know in writing of your **external appeal** rights under the Medicare or Medi-Cal program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

Additional Appeal Rights under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

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The **Medicare program** contracts with an "Independent Review Organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if **CalOptima PACE** wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service(s). However, you may have to pay for the service(s) if the decision is not in your favor.

If you are enrolled in **Medicare Medi-Cal program or both,** we will help you choose which external appeal process you should follow. We also will send your appeal on to the appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal options are described below.

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Medi-Cal External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-17-37
Sacramento, CA 94244-2430
Telephone: (800)-952-5253
Facsimile: (916) 651-5210 or (916) 651-2789
TDD: (800)-952-8349

If you choose to request a State hearing, you must ask for it within ninety (90) days from the date of receiving the *Notice of Action (NOA) for Service or Payment Request* from **CalOptima PACE**.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend, or an attorney. You may also be able to get free legal help. Attached is a list of Legal Services offices in **Orange County**, if you would like legal services assistance.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, **CalOptima PACE** will follow the judge's instruction as to the timeframe for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is **not** in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeals, and we will assist you in pursuing your appeal.

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Medicare External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medicare only,** and choose to appeal our decision using Medicare's external appeals process, we will send your appeal file to the current contracted Medicare appeals entity to impartially review the appeal. The contracted Medicare appeals entity will contact us with the results of their review. The contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor. The current Medicare appeals entity is:

Maximus Federal Services
Medicare Managed Care & PACE
Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14524-1302
Telephone: (585) 348-3300
Facsimile: (585) 425-5292

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of Modifications of CalOptima Policies and Procedures Related to CalOptima's Whole-Child Model (WCM) Program

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

Approve modifications to the following Policies and Procedures in connection with Whole-Child Model program as follows:

1. DD.2006: Enrollment In/ Eligibility with CalOptima [Medi-Cal]
2. DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process [Medi-Cal]
3. GG.1125: Cancer Clinical Trials [Medi-Cal, OneCare, OneCare Connect]
4. GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices [Medi-Cal]

Background

The California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children under age 21 who meet eligibility criteria based on financial and medical conditions. Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal Managed Care Plan (MCP) contracts for County Organized Health Systems (COHS) on a phased-in basis.

On November 9, 2018, DHCS delayed the implementation of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS determined that more time is needed to ensure effective preparation and a robust number of CCS-paneled providers. On November 21, 2018 and December 18, 2018, DHCS provided updated WCM provider network adequacy standards that all CalOptima health networks must meet in order to participate in the WCM. Additionally, on December 23, 2018, DHCS released All Plan Letter (APL) 18-023 California Children's Services Whole-Child Model, which superseded the APL originally published on June 7, 2018, and included clarifying language and new guidance regarding Neonatal Intensive Care Unit (NICU), High Risk Infant Follow-up (HRIF) program, pediatric palliative care, and continuity of care appeals.

On December 6, 2018, the CalOptima Board of Directors authorized modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program to no sooner than July 1, 2019. Additional policies and procedure require

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modification due to the delayed WCM implementation date, provider network adequacy standards and regulatory guidance.

Discussion

DHCS released updated network adequacy standards for 27 identified provider types and specialties on November 21, 2018, which was further updated on December 18, 2018. CalOptima's health networks are required to contract with 23 of the 27 identified provider types and CalOptima is responsible for contracting with the remaining four on behalf of the entire network. The remaining four specialty types are considered rare specialties and include, Pediatric Dermatology, Pediatric Developmental and Behavioral Medicine, Oral and Maxillofacial Surgery and Transplant Hepatology. Health networks must meet the adequacy standards as certified by DHCS to participate in WCM. Members may only receive CCS services through a participating health network.

All health networks are expected to meet applicable network adequacy requirements; final evidence of network adequacy was submitted to DHCS on March 1, 2019. Network adequacy will be evaluated, at a minimum, on an annual basis. While not expected, CalOptima has modified its policy and procedures to ensure that members eligible for CCS are not assigned to a health network not participating in WCM. Additionally, processes were established to notify members assigned to a health network that is later determined to not meet WCM provider network adequacy standards.

Below is additional information regarding the modified policies which include revisions related to WCM as well as clarification related to existing operations:

1. ***DD.2006: Enrollment In/ Eligibility with CalOptima*** defines the criteria by which CalOptima enrolls a member in CalOptima Direct. CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory requirements including the WCM program. Revisions include modifications to the process for members undergoing a transplant to transition from a health network to CalOptima Community Network (CCN). With respect to WCM, the revisions clarify that transitioning members with select chronic conditions from delegated health networks to CalOptima Community Network will be effective on and after the WCM implementation date.

2. ***DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process*** describes the process in which a health network eligible member shall select CalOptima Community Network (CCN) or a health network, and CCN or the health network's responsibilities for such member. CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory requirements including the WCM program. With respect to WCM, the revisions address requirements that a member may only receive services through a WCM participating network that has met DHCS network adequacy requirements.

3. ***GG.1125: Cancer Clinical Trials*** outlines coverage guidelines for routine health care services provided in connection with a member's participation in a cancer clinical trial. CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory

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requirements including the WCM program. With respect to WCM, the revisions address CalOptima's expanded responsibility for Cancer Clinical Trials for CCS members under WCM.

4. ***GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices*** outlines the durable medical equipment (DME) guidelines and medical necessity criteria for reimbursement of medically necessary automobile orthopedic positioning devices (AOPD). CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory requirements including the WCM program. With respect to WCM, the revisions address CalOptima's expanded responsibility for AOPD for CCS members under WCM.

Additional policies are expected to be submitted for Board approval at a later time.

Fiscal Impact
The recommended action to modify existing policies and procedures, DD.2006, DD.2008, GG.1125 and GG.1515 in connection with the WCM program is not expected to have an additional fiscal impact beyond CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks, approved by the Board on October 4, 2018. Management will include all projected revenues and expenses associated with the WCM program in the Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation
To ensure CalOptima meets all requirements of the Whole-Child Model program, approval of the requested actions is recommended.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. DD.2006: Enrollment In/ Eligibility with CalOptima (redline and clean versions)
2. DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process (redline and clean versions)
3. GG.1125: Cancer Clinical Trials (redline and clean versions)
4. GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices (redline and clean versions)
5. Board Action December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date
6. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program
7. DHCS All Plan Letter 18-011 California Children's Services Whole-Child Model Program

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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Policy #: DD.2006
Title: **Enrollment In/Eligibility with CalOptima Direct**
Department: Customer Service
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 10/01/1995
Revision Date: 04/04/2019

I. PURPOSE

This policy defines the criteria by which CalOptima enrolls a **Member** in **CalOptima Direct**.

II. POLICY

A. CalOptima may enroll a **Member** in **CalOptima Direct**, in accordance with this Policy.

B. CalOptima shall enroll the following **Members** in **CalOptima Direct Administrative (COD-A)** subject to the provisions of this Policy:

1. A **Member** who has Medicare coverage and is not enrolled in OneCare or OneCare Connect~~:~~.

~~1. For a Member who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in CalOptima Direct pursuant to this policy, CalOptima shall not be required to assign such Members who are eligible for services through Medicare to a Medi-Cal Primary Care Provider (PCP) or require them to select a Medi-Cal PCP in accordance with the policy of the Department of Health Care Services (DHCS).~~
A **member**
~~2. For a Member who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in CalOptima Direct, pursuant to this policy, CalOptima shall assign such Member to a Medi-Cal PCP in accordance with DHCS policy(s).~~

2. ~~A Member~~ who becomes the responsibility of the Public Guardian or is in an Institute for Mental Disease (IMD), or with Orange County Children and Family Services and ~~is~~ placed outside of Orange County.

3. A **Member** with a **Share of Cost (SOC) Aid Code**.

4. A **Member** who resides at the Fairview Developmental Center.

5. At the time of initial enrollment in CalOptima, a **Member** with a non-Orange County zZip cCode, or invalid address information from the State.

a. If the address and/or zip code changes to an Orange County address at a later date, CalOptima shall request that the **Member** select a **Health Network** or **CalOptima Community Network (CCN)**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

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

C. CalOptima shall enroll a **Member** in **CCN in the following circumstances**, unless eligible for enrollment in **COD-A** ~~as described above, subject to the following provisions of this Policy:~~under Section II.B.:

1. A **Member** with Long Term Care (LTC) **Aid Code**;

2. A **Member** with a Breast and Cervical Cancer Treatment Program (BCCTP) primary **Aid Code**;

3. A **Health Network Eligible Member**, except as otherwise identified in this Policy~~:~~, who is at least twenty-one (21) years old. The age provision shall no longer apply on and after the implementation date of the Department of Health Care Services (DHCS) approved Whole-Child Model (WCM) program, and:

   a. Is diagnosed with hemophilia;

   b. Is listed for a **Solid Organ Transplant** or approved for a Bone Marrow Transplant (BMT). ~~identified by a Provider as a potential candidate for a Solid Organ Transplant at a DHCS-approved Transplant Center or a **California Children's Services (CCS)** paneled Transplant Special Care Center, and the Provider has requested authorization for Covered Services, or is approved for a Bone Marrow Transplant (BMT), except if the Member is listed as **Status 7**;~~

   c. Has received a **Solid Organ Transplant** or BMT within one hundred twenty (120) calendar days prior to the **Member's** effective date of enrollment in CalOptima; or

   d. Is diagnosed with **End Stage Renal Disease (ESRD)**.

~~Notwithstanding Section II.C.3., **members** under the age of twenty-one (21) years shall not be assigned to CCN. This provision shall no longer apply on and after the implementation date of the Department of Health Care Services (DHCS) approved Whole-Child Model (WCM) program.~~

D. If a **Member** is no longer required to be enrolled in **COD-A** or **CCN** as described in Sections II.B or II.C, such **Member**:

1. Is a **Health Network Eligible Member**;

2. May select **CalOptima Community Network** or any other **Health Network** in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

E. CalOptima shall exclude a **Health Network Eligible Member** from the provisions of this P~~p~~olicy if such **Member** is enrolled in a **Health Maintenance Organization (HMO)** that, pursuant to the **Health Network's** Contract, is responsible for all **Covered Services** for the **Member**.

F. **COD-A** is responsible for a **Health Network Eligible Member** until such **Member** selects a **Health Network** or is assigned to a **Health Network**, pursuant to CalOptima Policies DD.2008:

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Health Network and CalOptima Community Network Selection Process or AA.1207a: CalOptima Auto-Assignment~~.~~, respectively.

G. **CalOptima Direct** is not responsible for **Covered Services** provided to a **Member** outside the United States, with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22, California Code of Regulations, Section 51006.

III. PROCEDURE

A. At the time of initial enrollment in CalOptima, a **Member** with a zip code outside of Orange County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to verify a zip code within Orange County due to no address information provided by the State, such **Member** shall not be auto-assigned by CalOptima, and the **Member** shall remain in **COD-A**.

B. If a **Member** assigned to **COD-A** due to having a zip code outside Orange County changes his or her zip code to an Orange County zip code, CalOptima shall request that the **Member** select a **Health Network** or **CCN**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto-assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

~~B.~~

C. If a current **Member** assigned to a **Health Network** has or receives a zip code outside of Orange County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to verify a zip code within Orange County at a later date, the **Member** may remain with their assigned **Health Network** unless **Member** makes a different **Health Network** choice or meets the criteria for **COD-A** or **CCN** enrollment as stated in Section II.B or II.C.

D. If a **Health Network Eligible Member** becomes the responsibility of the Public Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and Family Services and resides outside Orange County:

1. The ~~**Member's Public**~~**Member's** Public Guardian, or the Orange County Children and Family Services may submit a written request to enroll the **Member** in **COD-A**.

   a. If CalOptima receives such request to enroll the **Member** in **COD-A** by the tenth (10th) calendar day of the month, **CalOptima Direct** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1st) calendar day of the immediately following month.

   b. If CalOptima receives such request after the tenth (10th) calendar day of the month, **COD-A** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month.

2. If the **Member's** Public Guardian, ~~or Orange~~or Orange County Children and Family Services does not submit a written request to enroll the **Member** in **CalOptima Direct**, the **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **Division of Financial Responsibility (DOFR)**.

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3. If the **Member** returns to Orange County, the Public Guardian or Orange County Children and Family Services may submit a written request to enroll the **Member** in a **Health Network** or **CCN**.

E. If a **Health Network Eligible Member** is diagnosed with Hemophilia:

1. The **Member's Health Network** shall notify CalOptima of the **Member's** diagnosis, in writing, using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members.

   a. If the **Health Network** notifies CalOptima, in writing, by the tenth (10th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1st) calendar day of the ~~immediate~~immediately following month.

   b. If the **Health Network** notifies CalOptima, in writing, after the tenth (10th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, to enroll the **Member** in **CalOptima Direct**, and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.~~D~~E.1 of this Policy.

F. If a **Health Network Eligible Member**, is listed for a **Solid Organ Transplant** or approved for a BMT.~~identified by a Provider as a potential candidate for a Solid Organ Transplant at a DHCS-approved Transplant Center or a **CCS** paneled Transplant Special Care Center, and the Provider has requested authorization for Covered Services, or the Member is approved for Bone Marrow Transplant (BMT) at a DHCS-approved Transplant Center or **CCS** paneled Transplant Special Care Center, and is not listed as **Status 7:**~~

1. The **Member's Health Network** shall notify CalOptima, in writing, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

   a. Except as set forth in Section III.~~D~~F.1.b of this P~~p~~olicy, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**.

   b. If the **Member** receives a **Solid Organ Transplant** or BMT after the date the **Health Network** notifies CalOptima and before the first (1st) calendar day of the month immediately following the date CalOptima receives notice, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month of notice.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, and CalOptima transitions such **Member** to **CalOptima Direct** as set forth in Section III.~~D~~F.1. of this P~~p~~olicy.

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3. **CCN** shall be responsible for all **Covered Services** for the **Member** for three- hundred sixty-five (365) calendar days after the **Member** receives a **Solid Organ Transplant** or BMT. After three-hundred sixty-five (365) calendar days after the date the **Member** receives a **Solid Organ Transplant** or BMT, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

4. If CalOptima, the DHCS-approved Transplant Center, or the **CCS**-paneled Transplant Special Care Center, determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT:

   a. If it has been less than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective the first (1st) calendar day of the month immediately following the date CalOptima or the DHCS-approved Transplant Center determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT; or

   b. If it has been more than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network Selection Process, or CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

G. If a **Health Network Eligible Member**, except a Kaiser **Member**, is identified as a potential candidate for ~~received~~ a **Solid Organ Transplant** or a BMT: ~~within one hundred twenty (120) calendar days prior to their effective date of enrollment in CalOptima:~~

1. The **Member's Health Network** shall notify CalOptima by sending a Notification of Transplant Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

2. **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**, for a period of not less than three hundred sixty-five (365) calendar days after the date the **Member** received such Transplant.

3. CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective no later than the first (1st) calendar day of the month immediately following the three hundred sixty fifth (365th) calendar day after the date the **Member** received a **Solid Organ Transplant** or BMT.

4. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member** until the **Health Network** submits written notice and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.~~E~~G.1 and III.~~E~~G.2 of this Policy.

H. If a **Health Network Eligible Member** is diagnosed with **ESRD** and is not already assigned to **CCN**:

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1. The **Member's Health Network** shall notify CalOptima, in writing, of the **Member** by submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network Relations Department.

    a. If a **Health Network** submits a Form CMS-2728-U3 on or before the fifteenth (15th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the ~~immediate~~immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 15, **CCN** shall assume responsibility for the **Member** effective August 1.

    b. If a **Health Network** submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the second (2nd) month after the immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 16, **CCN** shall assume responsibility for the **Member** effective September 1.

    c. CalOptima shall provide the **Member** with a thirty (30) calendar day notice of the transition, pursuant to the CalOptima Contract with DHCS.

I. If CalOptima identifies a **Member** who meets the requirements specified in Sections II.B and II.C, of this P~~p~~olicy, CalOptima shall transition the **Member** to **COD-A**, or **CCN**, and notify the **Member's Health Network** of such transition. CalOptima shall provide the **Member**, with a thirty (30) calendar day notice of the transition pursuant to CalOptima's contract with DHCS.

1. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until CalOptima enrolls the **Member** in **COD-A** or **CCN**.

J. If CalOptima identifies a **Member** who meets the requirements specified in Section II.B.1.~~b~~ of this P~~p~~olicy, CalOptima shall assign the **Member** a **PCP** as follows:

1. For a **member** who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in **CalOptima Direct** pursuant to this P~~p~~olicy, CalOptima shall not be required to assign such **members** who are eligible for services through Medicare to a Medi-Cal **Primary Care Provider (PCP)** or require them to select a Medi-Cal **PCP** in accordance with the policy of the Department of Health Care Services (DHCS).

2. For a **member** who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in **CalOptima Direct**, pursuant to this P~~p~~olicy, CalOptima shall assign such **member** to a Medi-Cal **PCP** in accordance with DHCS policy(s).

3. For an existing **Member** assigned to a **Health Network**, who gains Part A-only Dual status, CalOptima shall transition the **Member** to **COD-A** in the month CalOptima is notified by the State of the change to Medicare Part A eligibility.

    a. CalOptima shall assign the **Member** a **PCP** in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

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4. For a newly enrolled **Member** who is also Medicare Part A-only Dual eligible, CalOptima shall assign the **Member** to a **PCP** in accordance with the methodology described in CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

5. A **Member** may request to change his or her participating **PCP** every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

IV. ATTACHMENT(S)

A. Notification of Transplant Member
B. Hemophilia Special Needs Screen Questionnaire
C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy FF.1001: Capitation Payment
H. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
~~H.~~I. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
~~I.~~J. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
~~J.~~K. California Health and Safety Code, §§ 104160 through 104163
~~K.~~L. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in Medi-Cal Managed Care for Dual-Eligible Beneficiaries
~~L.~~M. Department of Health Care Services All Plan Letter (APL) 18-~~011~~023: California Children's Services Whole Child Model Program
~~M.~~N. Title 22, California Code of Regulations, §51006
~~N.~~O. Welfare and Institutions Code, §14182.17(d)(3)

VI. REGULATORY AGENCY APPROVAL(S)

A. 10/07/15: Department of Health Care Services
B. 08/18/15: Department of Health Care Services
C. 04/01/15: Department of Health Care Services
D. 10/01/12: Department of Health Care Services

VII. BOARD ACTION(S)

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 09/06/18: Regular Meeting of the CalOptima Board of Directors

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~~B.~~C. 08/06/15: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 03/06/14: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 03/04/10: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 11/05/09: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 06/03/08: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 10/19/06: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~#	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	10/01/1995	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	02/01/1996	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	03/01/1997	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2006	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2007	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2008	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2010	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	01/01/2011	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	10/01/2012	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	03/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	05/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Reviewed	02/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	07/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/06/2018	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	04/04/2019	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

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~~X.~~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~~member is eligible to receive Medi-Cal ~~Covered Services~~covered services.
California Children's Services Program	~~For the purposes of this policy, the~~The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~persons~~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 (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (***PCP***) to manage the care of the ~~Member~~member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to ~~Members~~members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A ~~Member~~member who receives all ~~Covered Services~~covered services through CalOptima Direct.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
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~~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~~members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division ~~of~~Of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of ~~Covered Services.~~covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

Term	Definition
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide ~~Covered Services~~covered services to ~~Members~~members assigned to that ~~Health Network~~health network.
Health Network Eligible Member	A ~~Member~~member who is eligible to choose a CalOptima ~~Health Network~~health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to ~~Members~~members and serves as the medical home for ~~Members~~members.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; and 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

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Policy #:	DD.2006
Title:	**Enrollment In/Eligibility with CalOptima Direct**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	10/01/1995
Revision Date:	04/04/2019

I. PURPOSE

This policy defines the criteria by which CalOptima enrolls a **Member** in **CalOptima Direct**.

II. POLICY

A. CalOptima may enroll a **Member** in **CalOptima Direct**, in accordance with this Policy.

B. CalOptima shall enroll the following **Members** in **CalOptima Direct Administrative (COD-A)** subject to the provisions of this Policy:

1. A **Member** who has Medicare coverage and is not enrolled in OneCare or OneCare Connect.

2. A **member** who becomes the responsibility of the Public Guardian or is in an Institute for Mental Disease (IMD), or with Orange County Children and Family Services and placed outside of Orange County.

3. A **Member** with a **Share of Cost (SOC) Aid Code**.

4. A **Member** who resides at the Fairview Developmental Center.

5. At the time of initial enrollment in CalOptima, a **Member** with a non-Orange County zip code, or invalid address information from the State.

    a. If the address and/or zip code changes to an Orange County address at a later date, CalOptima shall request that the **Member** select a **Health Network** or **CalOptima Community Network (CCN)**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. CalOptima shall enroll a **Member** in **CCN in the following circumstances**, unless eligible for enrollment in **COD-A** under Section II.B.:

1. A **Member** with Long Term Care (LTC) **Aid Code**;

2. A **Member** with a Breast and Cervical Cancer Treatment Program (BCCTP) primary **Aid Code**;

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

3. A **Health Network Eligible Member**, except as otherwise identified in this Policy, who is at least twenty-one (21) years old. The age provision shall no longer apply on and after the implementation date of the Department of Health Care Services (DHCS) approved Whole-Child Model (WCM) program, and:

    a. Is diagnosed with hemophilia;

    b. Is listed for a **Solid Organ Transplant** or approved for a Bone Marrow Transplant (BMT).

    c. Has received a **Solid Organ Transplant** or BMT within one hundred twenty (120) calendar days prior to the **Member's** effective date of enrollment in CalOptima; or

    d. Is diagnosed with **End Stage Renal Disease (ESRD)**.

D. If a **Member** is no longer required to be enrolled in **COD-A** or **CCN** as described in Sections II.B or II.C, such **Member**:

1. Is a **Health Network Eligible Member**;

2. May select **CalOptima Community Network** or any other **Health Network** in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

E. CalOptima shall exclude a **Health Network Eligible Member** from the provisions of this Policy if such **Member** is enrolled in a **Health Maintenance Organization (HMO)** that, pursuant to the **Health Network's** Contract, is responsible for all **Covered Services** for the **Member**.

F. **COD-A** is responsible for a **Health Network Eligible Member** until such **Member** selects a **Health Network** or is assigned to a **Health Network**, pursuant to CalOptima Policies DD.2008: Health Network and CalOptima Community Network Selection Process or AA.1207a: CalOptima Auto-Assignment, respectively.

G. **CalOptima Direct** is not responsible for **Covered Services** provided to a **Member** outside the United States, with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22, California Code of Regulations, Section 51006.

III. PROCEDURE

A. At the time of initial enrollment in CalOptima, a **Member** with a zip code outside of Orange County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to verify a zip code within Orange County due to no address information provided by the State, such **Member** shall not be auto-assigned by CalOptima, and the **Member** shall remain in **COD-A**.

B. If a **Member** assigned to **COD-A** due to having a zip code outside Orange County changes his or her zip code to an Orange County zip code, CalOptima shall request that the **Member** select a **Health Network** or **CCN**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto-assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. If a current **Member** assigned to a **Health Network** has or receives a zip code outside of Orange County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to

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verify a zip code within Orange County at a later date, the **Member** may remain with their assigned **Health Network** unless **Member** makes a different **Health Network** choice or meets the criteria for **COD-A** or **CCN** enrollment as stated in Section II.B or II.C.

D. If a **Health Network Eligible Member** becomes the responsibility of the Public Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and Family Services and resides outside Orange County:

1. The **Member's** Public Guardian, or the Orange County Children and Family Services may submit a written request to enroll the **Member** in **COD-A**.

   a. If CalOptima receives such request to enroll the **Member** in **COD-A** by the tenth (10th) calendar day of the month, **CalOptima Direct** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1st) calendar day of the immediately following month.

   b. If CalOptima receives such request after the tenth (10th) calendar day of the month, **COD-A** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month.

2. If the **Member's** Public Guardian, or Orange County Children and Family Services does not submit a written request to enroll the **Member** in **CalOptima Direct**, the **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **Division of Financial Responsibility (DOFR)**.

3. If the **Member** returns to Orange County, the Public Guardian or Orange County Children and Family Services may submit a written request to enroll the **Member** in a **Health Network** or **CCN**.

E. If a **Health Network Eligible Member** is diagnosed with Hemophilia:

1. The **Member's Health Network** shall notify CalOptima of the **Member's** diagnosis, in writing, using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members.

   a. If the **Health Network** notifies CalOptima, in writing, by the tenth (10th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1st) calendar day of the immediately following month.

   b. If the **Health Network** notifies CalOptima, in writing, after the tenth (10th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, to enroll the **Member** in **CalOptima Direct**, and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.E.1 of this Policy.

F. If a **Health Network Eligible Member**, is listed for a **Solid Organ Transplant** or approved for a BMT.

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1. The **Member's Health Network** shall notify CalOptima, in writing, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

    a. Except as set forth in Section III.F.1.b of this Policy, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**.

    b. If the **Member** receives a **Solid Organ Transplant** or BMT after the date the **Health Network** notifies CalOptima and before the first (1st) calendar day of the month immediately following the date CalOptima receives notice, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month of notice.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, and CalOptima transitions such **Member** to **CalOptima Direct** as set forth in Section III.F.1. of this Policy.

3. **CCN** shall be responsible for all **Covered Services** for the **Member** for three- hundred sixty-five (365) calendar days after the **Member** receives a **Solid Organ Transplant** or BMT. After three-hundred sixty-five (365) calendar days after the date the **Member** receives a **Solid Organ Transplant** or BMT, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

4. If CalOptima, the DHCS-approved Transplant Center, or the **CCS-**paneled Transplant Special Care Center, determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT:

    a. If it has been less than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective the first (1st) calendar day of the month immediately following the date CalOptima or the DHCS-approved Transplant Center determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT; or

    b. If it has been more than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network Selection Process, or CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

G. If a **Health Network Eligible Member**, except a Kaiser **Member**, is identified as a potential candidate for a **Solid Organ Transplant** or a BMT:

1. The **Member's Health Network** shall notify CalOptima by sending a Notification of Transplant Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

2. **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**, for a period of not less than three hundred sixty-five (365) calendar days after the date the **Member** received such Transplant.

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3. CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective no later than the first (1st) calendar day of the month immediately following the three hundred sixty fifth (365th) calendar day after the date the **Member** received a **Solid Organ Transplant** or BMT.

4. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member** until the **Health Network** submits written notice and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.G.1 and III.G.2 of this Policy.

H. If a **Health Network Eligible Member** is diagnosed with **ESRD** and is not already assigned to **CCN**:

1. The **Member's Health Network** shall notify CalOptima, in writing, of the **Member** by submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network Relations Department.

a. If a **Health Network** submits a Form CMS-2728-U3 on or before the fifteenth (15th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 15, **CCN** shall assume responsibility for the **Member** effective August 1.

b. If a **Health Network** submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the second (2nd) month after the immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 16, **CCN** shall assume responsibility for the **Member** effective September 1.

c. CalOptima shall provide the **Member** with a thirty (30) calendar day notice of the transition, pursuant to the CalOptima Contract with DHCS.

I. If CalOptima identifies a **Member** who meets the requirements specified in Sections II.B and II.C, of this Policy, CalOptima shall transition the **Member** to **COD-A**, or **CCN**, and notify the **Member's Health Network** of such transition. CalOptima shall provide the **Member**, with a thirty (30) calendar day notice of the transition pursuant to CalOptima's contract with DHCS.

1. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until CalOptima enrolls the **Member** in **COD-A** or **CCN**.

J. If CalOptima identifies a **Member** who meets the requirements specified in Section II.B.1. of this Policy, CalOptima shall assign the **Member** a **PCP** as follows:

1. For a **member** who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in **CalOptima Direct** pursuant to this Policy, CalOptima shall not be required to assign such **members** who are eligible for services through Medicare to a Medi-Cal **Primary Care Provider (PCP)** or require them to select a Medi-Cal **PCP** in accordance with the policy of the Department of Health Care Services (DHCS).

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2. For a **member** who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in **CalOptima Direct**, pursuant to this Policy, CalOptima shall assign such **member** to a Medi-Cal **PCP** in accordance with DHCS policy(s).

3. For an existing **Member** assigned to a **Health Network**, who gains Part A-only Dual status, CalOptima shall transition the **Member** to **COD-A** in the month CalOptima is notified by the State of the change to Medicare Part A eligibility.

    a. CalOptima shall assign the **Member** a **PCP** in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

4. For a newly enrolled **Member** who is also Medicare Part A-only Dual eligible, CalOptima shall assign the **Member** to a **PCP** in accordance with the methodology described in CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

5. A **Member** may request to change his or her participating **PCP** every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

IV. ATTACHMENT(S)

A. Notification of Transplant Member
B. Hemophilia Special Needs Screen Questionnaire
C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy FF.1001: Capitation Payment
H. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
I. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
J. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
K. California Health and Safety Code, §§ 104160 through 104163
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in Medi-Cal Managed Care for Dual-Eligible Beneficiaries
M. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program
N. Title 22, California Code of Regulations, §51006
O. Welfare and Institutions Code, §14182.17(d)(3)

VI. REGULATORY AGENCY APPROVAL(S)

A. 10/07/15: Department of Health Care Services
B. 08/18/15: Department of Health Care Services

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C. 04/01/15: Department of Health Care Services
D. 10/01/12: Department of Health Care Services

VII. BOARD ACTION(S)

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
B. 09/06/18: Regular Meeting of the CalOptima Board of Directors
C. 08/06/15: Regular Meeting of the CalOptima Board of Directors
D. 03/06/14: Regular Meeting of the CalOptima Board of Directors
E. 03/04/10: Regular Meeting of the CalOptima Board of Directors
F. 11/05/09: Regular Meeting of the CalOptima Board of Directors
G. 06/03/08: Regular Meeting of the CalOptima Board of Directors
H. 10/19/06: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	10/01/1995	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	02/01/1996	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	03/01/1997	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2006	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2007	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2008	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2010	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	01/01/2011	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	10/01/2012	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	03/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	05/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Reviewed	02/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	07/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/06/2018	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	04/04/2019	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

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IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a member is eligible to receive Medi-Cal covered services.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
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 (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (***PCP***) to manage the care of the member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A member who receives all covered services through CalOptima Direct.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
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 defines how CalOptima identifies the responsible parties for components of medical associated with the provision of covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

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Term	Definition
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to members assigned to that health network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; and 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

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P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

ADULT TRANSPLANT NOTIFICATION AND REQUEST FORM

Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607

PHASE: ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

***** 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: _____ (Last / First) ☐ M ☐ F D.O.B. _____ Age: _____

Mailing Address: _____ City: _____ ZIP: _____ Phone: _____

Client Index # (CIN): _____

Referring Provider:

Provider NPI#: _____ TIN#: _____

Medi-Cal ID#: _____

Address: Phone: _____

Fax: _____

Office Contact: _____

Physician's Signature: _____

Diagnosis: _____ ICD-9: _____

TRANSPLANT TYPE
(CalOptima may redirect based on contract status or center availability)

BMT:	☐ Cedars	
DLI:	☐ Cedars	
Kidney:	☐ UCI	
Kidney Pancreas:	☐ California Pacific	☐ UCSF
Liver:	☐ Cedars	☐ USC
Liver and Kidney:	☐ Cedars	☐ USC
Lung:	☐ USC	
Heart:	☐ Cedars	☐ USC
Heart and Lung:	☐ Stanford	
Small Bowel:	☐ Cedars	☐ USC

☐ Inpatient ☐ Outpatient

Estimated Length of Stay: _____

Letter of Agreement (LOA) Requested

Date(s) of Service: _____ 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)

STATUS	Authorization Number #
☐ Approved ☐ Modified ☐ Denied	Signature: Date:
☐ Not Medically Indicated ☐ Not a Covered Benefit	Comments:
☐ Services Available In Network	

Back to Agenda

CalOptima
A Public Agency
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Special Needs Screen Questionnaire for Member with Hemophilia Transitioning from Health Networks to CalOptima Direct

☐ Hemophilia A ☐ Hemophilia B ☐ Hemophilia C ☐ von Willebrands Disease

Name: CIN #: Phone No: ( ) -

Health Network: HN Contact: Phone No: ( ) -

Primary Care Physician: Phone No: ( ) -

Treating Specialists: Phone No: ( ) -

Is Member currently in Case Management?

*If member is in case management, submit a case summary.

Planned Admissions or scheduled surgeries:

Name of Provider/Vendor: Phone No: ( ) -

Ordering Physician: Phone No: ( ) -

Date of Procedure: - - Type of Procedure:

Comments (include CPT and ICD-9 codes requested/authorized):

What factor is utilized?

Name of Provider/Vendor: Phone No: ( ) -

Ordering Physician: Phone No: ( ) -

Comments (include CPT and ICD-9 codes requested/authorized):

Has the member been hospitalized in the past six months? ☐ Yes ☐ No

If yes:

Hospital:

Diagnosis:

RX

(Please make copies of this page if additional space needed for medications)

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of person completing this form: Date: - -

PLEASE SEND A COPY OF ALL OPEN AUTHORIZATIONS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS *Check one:* ☐ Initial ☐ Re-entitlement ☐ Supplemental

1. Name *(Last, First, Middle Initial)*

2. Medicare Claim Number

3. Social Security Number

4. Date of Birth *(mm/dd/yyyy)*

5. Patient Mailing Address *(Include City, State and Zip)*

6. Phone Number *(including area code)*

7. Sex ☐ Male ☐ Female

8. Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino (Complete Item 9)

9. Country/Area of Origin or Ancestry

10. Race *(Check all that apply)*
☐ White
☐ Black or African American
☐ American Indian/Alaska Native
Print Name of Enrolled/Principal Tribe
☐ Asian
☐ Native Hawaiian or Other Pacific Islander*
*complete Item 9

11. Is patient applying for ESRD Medicare coverage? ☐ Yes ☐ No

12. Current Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance
☐ DVA ☐ Medicare Advantage ☐ Other ☐ None

13. Height INCHES ____ OR CENTIMETERS ____

14. Dry Weight POUNDS ____ OR KILOGRAMS ____

15. Primary Cause of Renal Failure *(Use ICD-10-CM Code)*

16. Employment Status *(6 mos prior and current status)*

Prior	Current	
☐	☐	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

17. Co-Morbid Conditions *(Check all that apply currently and/or during last 10 years)* *See instructions

a. ☐ Congestive heart failure
b. ☐ Atherosclerotic heart disease ASHD
c. ☐ Other cardiac disease
d. ☐ Cerebrovascular disease, CVA, TIA*
e. ☐ Peripheral vascular disease*
f. ☐ History of hypertension
g. ☐ Amputation
h. ☐ Diabetes, currently on insulin
i. ☐ Diabetes, on oral medications
j. ☐ Diabetes, without medications
k. ☐ Diabetic retinopathy
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☐ Toxic nephropathy
p. ☐ Alcohol dependence
q. ☐ Drug dependence*
r. ☐ Inability to ambulate
s. ☐ Inability to transfer
t. ☐ Needs assistance with daily activities
u. Institutionalized
☐ 1. Assisted Living
☐ 2. Nursing Home
☐ 3. Other Institution
v. ☐ Non-renal congenital abnormality
w. ☐ None

18. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
b. Was patient under care of a nephrologist? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
c. Was patient under care of kidney dietitian? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
d. What access was used on first outpatient dialysis: ___ AVF ___ Graft ___ Catheter ☐ Other
If not AVF, then: Is maturing AVF present? ☐ Yes ☐ No
Is maturing graft present? Yes No

19. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a.1. Serum Albumin (g/dl)			d. HbA1c	%	
a.2. Serum Albumin Lower Limit			e. Lipid Profile TC		
a.3. Lab Method Used (BCG or BCP)			LDL		
b. Serum Creatinine (mg/dl)			HDL		
c. Hemoglobin (g/dl)			TG		

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

20. Name of Dialysis Facility

21. Medicare Provider Number *(for item 20)*

22. Primary Dialysis Setting
☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

23. Primary Type of Dialysis
☐ Hemodialysis (Sessions per week____/hours per session____)
☐ CAPD ☐ CCPD ☐ Other

24. Date Regular Chronic Dialysis Began *(mm/dd/yyyy)*

25. Date Patient Started Chronic Dialysis at Current Facility *(mm/dd/yyyy)*

26. Has patient been informed of kidney transplant options? ☐ Yes ☐ No

27. If patient NOT informed of transplant options, please check all that apply:
☐ Medically unfit
☐ Patient has not been assessed
☐ Patient declines information
☐ Psychologically unfit
☐ Unsuitable due to age
☐ Other

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

28. Date of Transplant *(mm/dd/yyyy)*	29. Name of Transplant Hospital	30. Medicare Provider Number for Item 29

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

31. Enter Date *(mm/dd/yyyy)*	32. Name of Preparation Hospital	33. Medicare Provider number for Item 32

34. Current Status of Transplant *(if functioning, skip items 36 and 37)*	35. Type of Donor:
☐ Functioning ☐ Non-Functioning	☐ Deceased ☐ Living Related ☐ Living Unrelated
36. If Non-Functioning, Date of Return to Regular Dialysis *(mm/dd/yyyy)*	37. Current Dialysis Treatment Site
	☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

38. Name of Training Provider	39. Medicare Provider Number of Training Provider (for Item 38)
40. Date Training Began *(mm/dd/yyyy)*	41. Type of Training ☐ Hemodialysis a. ☐ Home b. ☐ In Center ☐ CAPD ☐ CCPD ☐ Other
42. This Patient is Expected to Complete *(or has completed)* Training and will Self-dialyze on a Regular Basis. ☐ Yes ☐ No	43. Date When Patient Completed, or is Expected to Complete, Training *(mm/dd/yyyy)*

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

44. Printed Name and Signature of Physician personally familiar with the patient's training			45. UPIN of Physician in Item 44
a.) Printed Name	b.) Signature	c.) Date *(mm/dd/yyyy)*	

E. PHYSICIAN IDENTIFICATION

46. Attending Physician *(Print)*	47. Physician's Phone No. *(include Area Code)*	48. UPIN of Physician in Item 46

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

49. Attending Physician's Signature of Attestation *(Same as Item 46)*	50. Date *(mm/dd/yyyy)*
51. Physician Recertification Signature	52. Date *(mm/dd/yyyy)*

53. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

54. Signature of Patient *(Signature by mark must be witnessed.)*	55. Date *(mm/dd/yyyy)*

G. PRIVACY STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-70-0520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the *Federal Register* notice cited above. You should be aware that P.L.100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

INSTRUCTIONS FOR COMPLETION OF END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

For whom should this form be completed:

This form SHOULD NOT be completed for those patients who are in acute renal failure. Acute renal failure is a condition in which kidney function can be expected to recover after a short period of dialysis, i.e., several weeks or months.

This form MUST BE completed within 45 days for ALL patients beginning any of the following:

Check the appropriate block that identifies the reason for submission of this form.

Initial

For all patients who initially receive a kidney transplant instead of a course of dialysis. For patients for whom a regular course of dialysis has been prescribed by a physician because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life. The first date of a regular course of dialysis is the date this prescription is implemented whether as an inpatient of a hospital, an outpatient in a dialysis center or facility, or a home patient.

The form should be completed for all patients in this category even if the patient dies within this time period.

Re-entitlement

For beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post- transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.

For beneficiaries who stopped dialysis for more than 12 months, have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant. These patients will be reapplying for Medicare ESRD benefits.

Supplemental

Patient has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

All items except as follows: To be completed by the attending physician, head nurse, or social worker involved in this patient's treatment of renal disease.

Items 15, 17-18, 26-27, 49-50: To be completed by the attending physician.
Item 44: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.
Items 54 and 55: To be signed and dated by the patient.

1. Enter the patient's legal name (Last, first, middle initial). Name should appear exactly the same as it appears on patient's social security or Medicare card.
2. If the patient is covered by Medicare, enter his/her Medicare claim number as it appears on his/her Medicare card.
3. Enter the patient's own social security number. This number can be verified from his/her social security card.
4. Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
5. Enter the patient's mailing address (number and street or post office box number, city, state, and ZIP code.)
6. Enter the patient's home area code and telephone number.
7. Check the appropriate block to identify sex.
8. Check the appropriate block to identify ethnicity. Definitions of the ethnicity categories for Federal statistics are as follows:

   Not Hispanic or Latino—A person of culture or origin not described below, regardless of race.

   Hispanic or Latino—A person of Cuban, Puerto Rican, or Mexican culture or origin regardless of race. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.
9. Country/Area of origin or ancestry—Complete if information is available or if directed to do so in question 8.
10. Check the appropriate block(s) to identify race. Definitions of the racial categories for Federal statistics are as follows:

    White—A person having origins in any of the original white peoples of Europe, the Middle East or North Africa.

    Black or African American—A person having origins in any of the black racial groups of Africa. This includes native-born Black Americans, Africans, Haitians and residents of non-Spanish speaking Caribbean Islands of African descent.

    American Indian/Alaska Native—A person having origins in any of the original peoples of North America and South America (including Central America) and who maintains Tribal affiliation or community attachment. Print the name of the enrolled or principal tribe to which the patient claims to be a member.

    Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

    Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.

DISTRIBUTION OF COPIES:

- Forward one copy of this form to the Social Security office servicing the claim.
- Forward one copy of this form to the ESRD Network Organization.
- Retain one copy of this form in the patient's medical records file.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0046. The time required to complete this information collection estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attention: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

11. Check the appropriate yes or no block to indicate if patient is applying for ESRD Medicare. Note: Even though a person may already be entitled to general Medicare coverage, he/she should reapply for ESRD Medicare coverage.

12. Check all the blocks that apply to this patient's current medical insurance status.

Medicaid—Patient is currently receiving State Medicaid benefits.

Medicare—Patient is currently entitled to Federal Medicare benefits.

Employer Group Health Insurance—Patient receives medical benefits through an employee health plan that covers employees, former employees, or the families of employees o former employees.

DVA—Patient is receiving medical care from a Department of Veterans Affairs facility.

Medicare Advantage—Patient is receiving medical benefits under a Medicare Advantage organization.

Other Medical Insurance—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, HMO/M+C organization, nor an employer group health insurance plan. Examples of other medical insurance are Railroad Retirement and CHAMPUS beneficiaries.

None—Patient has no medical insurance plan.

13. Enter the patient's most recent recorded height in inches OR centimeters at time form is being completed. If entering height in centimeters, round to the nearest centimeter. Estimate or use last known height for those unable to be measured. (Example of inches - 62. DO NOT PUT 5'2") NOTE: For amputee patients, enter height prior to amputation.

14. Enter the patient's most recent recorded dry weight in pounds OR kilograms at time form is being completed. If entering weight in kilograms, round to the nearest kilogram.

NOTE: For amputee patients, enter actual dry weight.

15. To be completed by the attending physician. Enter the ICD10-CM Code to indicate the primary cause of end stage renal disease.

16. Check the first box to indicate employment status 6 months prior to renal failure and the second box to indicate current employment status. Check only one box for each time period. If patient is under 6 years of age, leave blank.

17. To be completed by the attending physician. Check all co-morbid conditions that apply.

*Cerebrovascular Disease includes history of stroke/cerebrovascular accident (CVA) and transient ischemic attack (TIA).

*Peripheral Vascular Disease includes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.

*Drug dependence means dependent on illicit drugs.

18. Prior to ESRD therapy, check the appropriate box to indicate whether the patient received exogenous erythropoietin (EPO) or equivalent, was under the care of a nephrologist and/or was under the care of a kidney dietitian. Provide vascular access information as to the type of access used (Arterio-Venous Fistula (AVF), graft, catheter (including port device) or other type of access) when the patient first received outpatient dialysis. If an AVF access was not used, was a maturing AVF or graft present?

NOTE: For those patients re-entering the Medicare program after benefits were terminated, Items 19a thru 19c should contain initial laboratory values within 45 days prior to the most recent ESRD episode. Lipid profiles and HbA1c should be within 1 year of the most recent ESRD episode. Some tests may not be required for patients under 21 years of age.

19a1. Enter the serum albumin value (g/dl) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or kidney transplant.

19a2. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in 19a1.

19a3. Enter the serum albumin lab method used (BCG or BCP).

19b. Enter the serum creatinine value (mg/dl) and date test was taken. THIS FIELD MUST BE COMPLETED. Value must be within 45 days prior to first dialysis treatment or kidney transplant.

19c. Enter the hemoglobin value (g/dl) and date test was taken. This value and date must be within 45 days prior to the first dialysis treatment or kidney transplant.

19d. Enter the HbA1c value and the date the test was taken. The date must be within 1 year prior to the first dialysis treatment or kidney transplant.

19e. Enter the Lipid Profile values and date test was taken. These values: TC–Total Cholesterol; LDL–LDL Cholesterol; HDL–HDL Cholesterol; TG–Triglycerides, and date must be within 1 year prior to the first dialysis treatment or kidney transplant.

20. Enter the name of the dialysis facility where patient is currently receiving care and who is completing this form for patient.

21. Enter the 6-digit Medicare identification code of the dialysis facility in item 20.

22. If the person is receiving a regular course of dialysis treatment, check the appropriate anticipated long-term treatment setting at the time this form is being completed.

23. If the patient is, or was, on regular dialysis, check the anticipated long-term primary type of dialysis: Hemodialysis, (enter the number of sessions prescribed per week and the hours that were prescribed for each session), CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis), or Other. Check only one block. NOTE: Other has been placed on this form to be used only to report IPD (Intermittent Peritoneal Dialysis) and any new method of dialysis that may be developed prior to the renewal of this form by Office of Management and Budget.

24. Enter the date (month, day, year) that a "regular course of chronic dialysis" began. The beginning of the course of dialysis is counted from the beginning of regularly scheduled dialysis necessary for the treatment of end stage renal disease (ESRD) regardless of the dialysis setting. The date of the first dialysis treatment after the physician has determined that this patient has ESRD and has written a prescription for a "regular course of dialysis" is the "Date Regular Chronic Dialysis Began" regardless of whether this prescription was implemented in a hospital/ inpatient, outpatient, or home setting and regardless of any acute treatments received prior to the implementation of the prescription.

NOTE: For these purposes, end stage renal disease means irreversible damage to a person's kidneys so severely affecting his/her ability to remove or adjust blood wastes that in order to maintain life he or she must have either a course of dialysis or a kidney transplant to maintain life.

If re-entering the Medicare program, enter beginning date of the current ESRD episode. Note in Remarks, Item 53, that patient is restarting dialysis.

25. Enter date patient started chronic dialysis at current facility of dialysis services. In cases where patient transferred to current dialysis facility, this date will be after the date in Item 24.

26. Enter whether the patient has been informed of their options for receiving a kidney transplant.

27. If the patient has not been informed of their options (answered "no" to Item 26), then enter all reasons why a

kidney transplant was not an option for this patient at this time.

28. Enter the date(s) of the patient's kidney transplant(s). If reentering the Medicare program, enter current transplant date.
29. Enter the name of the hospital where the patient received a kidney transplant on the date in Item 28.
30. Enter the 6-digit Medicare identification code of the hospital in Item 29 where the patient received a kidney transplant on the date entered in Item 28.
31. Enter date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation. This includes hospitalization for transplant workup in order to place the patient on a transplant waiting list.
32. Enter the name of the hospital where patient was admitted as an inpatient in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation.
33. Enter the 6-digit Medicare identification number for hospital in Item 32.
34. Check the appropriate functioning or non-functioning block.
35. Enter the type of kidney transplant organ donor, Deceased, Living Related or Living Unrelated, that was provided to the patient.
36. If transplant is nonfunctioning, enter date patient returned to a regular course of dialysis. If patient did not stop dialysis post-transplant, enter transplant date.
37. If applicable, check where patient is receiving dialysis treatment following transplant rejection. A nursing home or skilled nursing facility is considered as home setting

Self-dialysis Training Patients (Medicare Applicants Only)

Normally, Medicare entitlement begins with the third month after the month a patient begins a regular course of dialysis treatment. This 3-month qualifying period may be waived if a patient begins a self-dialysis training program in a Medicare approved training facility and is expected to self-dialyze after the completion of the training program. Please complete items 38-43 if the patient has entered into a self-dialysis training program. Items 38-43 must be completed if the patient is applying for a Medicare waiver of the 3-month qualifying period for dialysis benefits based on participation in a self-care dialysis training program.

38. Enter the name of the provider furnishing self-care dialysis training.
39. Enter the 6-digit Medicare identification number for the training provider in Item 38.
40. Enter the date self-dialysis training began.
41. Check the appropriate block which describes the type of self-care dialysis training the patient began. If the patient trained for hemodialysis, enter whether the training was to perform dialysis in the home setting or in the facility (in center). If the patient trained for IPD (Intermittent Peritoneal Dialysis), report as Other.
42. Check the appropriate block as to whether or not the physician certifies that the patient is expected to complete the training successfully and self-dialyze on a regular basis.
43. Enter date patient completed or is expected to complete self-dialysis training.
44. Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.
45. Enter the Unique Physician Identification Number (UPIN) of physician in Item 44. (See Item 48 for explanation of UPIN.)
46. Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.
47. Enter the area code and telephone number of the physician who is supervising the patient's renal treatment at the time this form is completed.
48. Enter the physician's UPIN assigned by CMS.

    A system of physician identifiers is mandated by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985. It requires a unique identifier for each physician who provides services for which Medicare payment is made. An identifier is assigned to each physician regardless of his or her practice configuration. The UPIN is established in a national Registry of Medicare Physician Identification and Eligibility Records (MPIER). Transamerica Occidental Life Insurance Company is the Registry Carrier that establishes and maintains the national registry of physicians receiving Part Medicare payment. Its address is: UPIN Registry, Transamerica Occidental Life, P.O. Box 2575, Los Angeles, CA 90051-0575.
49. To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in Item 46. A stamped signature is unacceptable.
50. Enter date physician signed this form.
51. To be signed by the physician who is currently following the patient. If the patient had decided initially not to file an application for Medicare, the physician will be re-certifying that the patient is end stage renal, based on the same medical evidence, by signing the copy of the CMS-2728 that was originally submitted and returned to the provider. If you do not have a copy of the original CMS-2728 on file, complete a new form.
52. The date physician re-certified and signed the form.
53. This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office.
54. The patient's signature authorizing the release of information to the Department of Health and Human Services must be secured here. If the patient is unable to sign the form, it should be signed by a relative, a person assuming responsibility for the patient or by a survivor.
55. The date patient signed form.

Policy #:	DD.2008
Title:	**Health Network and CalOptima Community Network Selection Process**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/1995
~~Last Review Date:~~	~~06/01/18~~
~~Last~~ Revised Date:	~~06/01/18~~04/04/2019

I. PURPOSE

This policy describes the process by which a Health Network Eligible Member shall select **CalOptima Community Network (CCN)** or a Health Network, and **CCN's** or the Health Network's responsibilities for such Member.

II. POLICY

A. CalOptima is committed to a Health Network Eligible Member's right to choose **CCN** or a Health Network. CalOptima also recognizes that it is in the best interest of a Member to establish a medical home and maintain Continuity **of** Care with a **Primary Care Provider (PCP)**.

B. CalOptima shall request a Health Network Eligible Member select **CCN** or a Health Network, in accordance with the terms and conditions of this policy.

1. Except as otherwise provided in this policy, a Health Network Eligible Member may select **CCN** or any Health Network that is accepting new Members.

2. Effective January 1, 2007, only a Member who is less than twenty-one (21) years of age may enroll in CHOC Health Alliance, as set forth in Section III.B of this policy.

3. On or after the effective date of the CalOptima Whole-Child Model program, a **member** who is known to be participating in California's Children Services (CCS) may only enroll in a **health network** that is participating in the Whole-Child Model program.

C. A Health Network Eligible Member who does not select **CCN** or a Health Network shall be subject to the Auto-Assignment process, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

D. CalOptima recognizes that Family Linked Members may be best served by a single Health Network to ensure coordinated delivery of services by a Provider who is knowledgeable about the diverse needs of all of the Members in the family. To facilitate this objective, CalOptima shall assign a Family Linked Member whose family includes a Member already enrolled in a Health Network or **CCN**, to that Health Network or **CCN**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

1. On and after January 1, 2007, except as otherwise provided in this policy, CalOptima shall assign a Family Linked Member to the same Health Network as his or her youngest sibling if such Family Linked Member is under the age of twenty-one (21) years~~.~~.

2. If a Family Linked Member is over the age of twenty-one (21) years and his or her youngest sibling is enrolled in CHOC Health Alliance, CalOptima shall assign the Family Linked Member to the Health Network of another family **member**, if applicable.

3. On or after the effective date of the CalOptima Whole-Child Model program, if the **member** is known to be eligible with the Whole-Child Model program/**California Children Services Program (CCS)** and the **member's** youngest sibling is assigned to a **health network** that does not participate in the WCM/**CCS** program, the Family Link process will not apply.

E. A Health Network Eligible Member may change his or her Health Network or select **CCN** for any reason every thirty (30) calendar days, in accordance with this policy.

F. **CCN** or a Health Network shall be responsible for providing Covered Services to its Members, in accordance with its contract and applicable statutes, regulations, CalOptima policies, and other requirements of the CalOptima program.

1. If a Health Network Eligible Member moves outside of Orange County, his or her Health Network shall remain responsible for all Covered Services until the Member is no longer enrolled in the CalOptima program. If a Health Network Eligible Member becomes the responsibility of the Public Administrator/Public Guardian or is in an Institute for Mental Disease and is placed outside of Orange County, his or her Health Network shall continue to be responsible for all Covered Services until the Health Network or the Public Administrator /Public Guardian submits a request to enroll the Member in CalOptima Direct, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

2. If a Member becomes the responsibility of the Foster Care Program, **CCN** or his or her Health Network shall remain responsible for all Covered Services. The Member's foster parent, legal guardian, or the Orange County ~~Children's~~Children & Family Services Department may request to transition the Member into **CalOptima Direct (COD) – Administrative (COD-A)**, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

G. **CCN** or a Health Network shall not be responsible for Covered Services provided to a Member outside the United States with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22 of the California Code of Regulations, Section 51006.

H. CalOptima or a Health Network shall ensure Continuity **of** Care for Members who transition into CalOptima in accordance with CalOptima Policy GG.1325: Coordination of Care for ~~Newly Enrolled Medi-Cal~~ Members Transitioning into CalOptima Services.

I. In the event that a **member** is required to change **health network**s, due to **health network** termination or participation status of a **health network** in the Whole-Child Model program, CalOptima and the receiving **health network** shall collaborate to coordinate the provision of **covered services** for the affected **member**, in accordance with CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination.

III. PROCEDURE

Back to Agenda

A. **CCN** or **Health Network** Selection Process

1. Upon receipt of the Member's eligibility information from the Department of Health Care Services (DHCS), CalOptima shall send an enrollment packet to a Health Network Eligible Member. The enrollment packet shall include, but not be limited to, the following information:

   a. Introductory/welcome letter;

   b. CalOptima **Health Network** Selection Form;

   c. Health Information Form;

   d. CalOptima **Member** Handbook;

   e. CalOptima **Member** Identification Card;

   f. Invitation to a **Member** orientation;

   g. **Health Network** report card;

   h. **Health Network** Listing and Provider Directory; and

   i. Postage-paid envelope to return materials to CalOptima.

2. Only a Health Network Eligible Member or the Member's Authorized Representative shall sign a Health Network Selection Form on behalf of the Member. CalOptima shall not accept a **Health Network** Selection Form submitted without the signature of the Member or an Authorized Representative.

   a. CalOptima shall not accept responsibility for an inappropriately signed **Health Network** Selection Form.

3. CalOptima realizes that in some instances, such as time-sensitive health care appointments or challenges with valid home addresses, it is in the best interest of the Member to allow a change of Health Network or **CCN** selection request to be made by the Member or the Member's Authorized Representative over the phone~~.~~ in accordance with CalOptima Policy DD.2006b:CalOptima Community Network Member Primary Care Provider Selection/Assignment. In those circumstances, the request will be recorded and processed by the Customer Service Representative at the time of request.

4. If CalOptima receives a Health Network Eligible Member's completed **Health Network** Selection Form by the tenth (10th) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1st) calendar day of the immediately following month. If CalOptima receives a Member's completed **Health Network** Selection Form after the tenth (10th) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1st) calendar day of the month after the immediately following month.

5. A Health Network Eligible Member who has not selected a Health Network or **CCN** within the designated timeframe shall be automatically assigned to a Health Network pursuant to CalOptima Policy AA.1207a: CalOptima Auto-Assignment. Following the assignment of a ~~Health Network Eligible~~ Member in accordance with this policy, CalOptima shall notify the Member in writing of the assignment.

6. CalOptima may apply the following criteria to Member assignments to Health Networks or **CCN**:

   a. Consistent with the provisions of this policy and CalOptima Policy AA.1207a: CalOptima Auto-Assignment Policy, CalOptima shall assign Family Linked Members to the same Health Network or **CCN**.

   b. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility less than three hundred sixty-five (365) calendar days, CalOptima shall assign the Health Network Eligible Member to **CCN** or the last Health Network to which the Member was enrolled.

   c. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility more than three hundred sixty-five (365) calendar days, CalOptima shall treat such Health Network Eligible Member as a new Member, in accordance with this policy.

7. If a Health Network contract with CalOptima is terminated, ~~a Member~~or a health network is no longer participating in the Whole-Child Model Program a **member** who is enrolled in that Health Network may choose a new Health Network or **CCN**, in accordance with this policy.

   a. If the Member does not select a new Health Network or **CCN** prior to the contract termination of the Member's current Health Network, CalOptima shall assign such Member to:

      i. A Health Network of the Member's **PCP**'s choice if the Member's **PCP**, as shown in CalOptima's system, is contracted with at least one (1) other Health Network; or

      ii. A Health Network based on Auto Assignment.

8. A Health Network Eligible Member may change his or her **PCP** every thirty (30) calendar days for any reason~~. A Health Network or CCN shall process a Health Network Eligible Member's request to change his or her PCP.~~

B. **Member**s eligible for enrollment in CHOC Health Alliance

1. ~~A Member~~Subject to other limitations set forth in this policy, a **member** who meets criteria set forth in Section II.B.2 of this policy may select CHOC Health Alliance.

2. CalOptima shall assign a new Health Network Eligible Member to CHOC Health Alliance, in accordance with Policy AA.1207a: CalOptima Auto-Assignment.

3. Except as otherwise provided in Section ~~H~~III.B.4 of this policy, a 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 the following:

    a. CalOptima shall provide the Member with a ninety (90), sixty (60) and thirty (30) calendar day written notice to select **CCN** or another Health Network prior to the Member's twenty-first (21st) birthday. The written notices shall inform the Member that CHOC will only provide health care service until the end of the Member's twenty-first (21st) birth month.

    b. If the Member does not select **CCN** or another Health Network within the designated timeframe, CalOptima shall assign the Member to **CCN** or a Health Network as follows:

        i. If the Member's **PCP** is contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network of the Member's **PCP**'s choice; or

        ii. If the Member's **PCP** is not contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network based on geographic access.

    c. The Member shall be enrolled in **CCN** or the new Health Network effective the first (1st) calendar day of the month immediately following the Member's twenty-first (21st) birthday.

4. A Member shall remain in CHOC Health Alliance beyond the Member's twenty-first (21st) birthday if the Member meets all of the following criteria:

    a. **Member** is diagnosed with one (1) of the following **California Children's Services (CCS)**-Eligible Conditions:

        i. Cystic Fibrosis;

        ii. A rare metabolic ~~disorders~~disorder not including Phenylketonuria (PKU);

        iii. Spina Bifida; or

        iv. Muscular Dystrophy.

    b. **Member** is eligible to receive services from **CCS** for the **CCS**-Eligible Condition as of the day before the Member's twenty-first (21st) birthday; and

    c. **Member** is receiving care for the **CCS**-Eligible Condition from a pediatric specialist who is contracted with CHOC Health Alliance as of the day before the Member's twenty-first (21st) birthday.

    d. A Member who remains in CHOC Health Alliance pursuant to Section III.B.4.a of this policy shall remain in CHOC Health Alliance until:

        i. The Member selects **CCN** or another Health Network; or

ii. The Member's pediatric specialist determines that the Member's care may safely be transitioned to **CCN** or another Health Network.

~~5. CalOptima and CHOC Health Alliance shall begin developing a transition plan for a Member who is enrolled in CHOC Health Alliance and who has a CCS-Eligible Condition no later than the Member's twentieth (20th) birthday, in accordance with CalOptima Policy GG.1101: California Children's Services.~~

C. If a Health Network Eligible Member moves outside of Orange County, the Member's Health Network or **CCN** shall continue to be responsible for Covered Services until the Member is no longer enrolled in the CalOptima program.

1. Upon notice that a Health Network Eligible Member has moved outside of Orange County, **CCN** or a Health Network shall attempt to verify this information with the Member. **CCN** or the Health Network shall instruct the Member to contact the County of Orange Social Services Agency or the United States Social Security Administration to report a change of address.

2. A Health Network or **CCN provider** shall notify CalOptima of a Health Network Eligible Member's change of address by submitting a Medi-Cal Contact Information Request Form (MC 354) to the CalOptima Customer Service Department.

3. Upon notice that a Health Network Eligible Member has moved out of Orange County, CalOptima shall send the Member's new residence information to the County of Orange Social Services Agency, in accordance with Title 22 of the California Code of Regulations, Section 50188, or to the U.S. Social Security Administration.

D. CalOptima recognizes that a situation may occur in which the needs of a Family Linked Member may not be best served by enrollment in the same Health Network as other Members in his or her family in accordance with Section II.D of this policy. A Family Linked Member may contact CalOptima's Customer Service Department to request enrollment in **CCN** or a different Health Network from other Members in his or her family.

IV. ATTACHMENTS

A. Health Network Selection Form
B. CalOptima Introductory Letter

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
~~D.~~E. CalOptima Policy GG.1101: California Children's Services
F. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
~~E.~~G. CalOptima Policy GG.1325: Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima

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~~F.~~H. Contract for Health Care Services
~~G.~~I. Medi-Cal Managed Care Division (MMCD) All-Plan Letter (APL) 03-002: SB 87 Medi-Cal Contact Information Release Form
~~H.~~J. Title 22, California Code of Regulations, §§50188, 51006, and 51301 et seq.

VI. REGULATORY AGENCY APPROVALS

A. 11/09/17: Department of Health Care Services
B. 06/24/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 08/07/14: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 10/03/06: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 08/30/06: Special Meeting of the CalOptima Board of Directors

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VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	10/01/1995	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	02/20/1997	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	07/01/2004	DD.1114	Request from Members of Same Household to Enroll in Different Health Networks	Medi-Cal
Revised	09/01/2004	DD.1109	Health Network Selection and Health Network Obligations for Members	Medi-Cal
Revised	01/01/2007	DD.2008	Health Network Selection Process	Medi-Cal
Revised	01/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	12/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	03/01/2015	DD.2008	Health Network Selection Process	Medi-Cal
Revised	04/01/2016	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2017	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2018	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal
Revised	04/04/2019	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal

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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 (21) years who have CCS ~~Eligible Conditions~~eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the ~~Members~~members.
CalOptima Direct – Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CCS-Eligible Conditions	~~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~~, Section 41800~~ sections 41515.2 through ~~4187.6 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 Accidents, poisonings, violence, and immunization reactions~~41518.9..
Continuity of Care	Services provided to a ~~Member~~member rendered by an out-of-network provider with whom the ~~Member~~member has pre-existing provider relationship.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as ~~Covered Services~~covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51310 of Title 22, CCR), which shall be covered for ~~Members~~members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Family Linked Member	A ~~Member~~member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another ~~Member~~member who is in his or her family and who resides in the same household.
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~~covered services to ~~Members~~members assigned to that ~~Health Network~~health network.
Health Network Eligible Member	A ~~Member~~member who is eligible to choose a CalOptima ~~Health Network~~health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members.
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.~~covered services.

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Policy #:	DD.2008
Title:	**Health Network and CalOptima Community Network Selection Process**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/1995
Revised Date:	04/04/2019

I. PURPOSE

This policy describes the process by which a Health Network Eligible Member shall select **CalOptima Community Network (CCN)** or a Health Network, and **CCN's** or the Health Network's responsibilities for such Member.

II. POLICY

A. CalOptima is committed to a Health Network Eligible Member's right to choose **CCN** or a Health Network. CalOptima also recognizes that it is in the best interest of a Member to establish a medical home and maintain Continuity **of** Care with a **Primary Care Provider (PCP)**.

B. CalOptima shall request a Health Network Eligible Member select **CCN** or a Health Network, in accordance with the terms and conditions of this policy.

1. Except as otherwise provided in this policy, a Health Network Eligible Member may select **CCN** or any Health Network that is accepting new Members.

2. Effective January 1, 2007, only a Member who is less than twenty-one (21) years of age may enroll in CHOC Health Alliance, as set forth in Section III.B of this policy.

3. On or after the effective date of the CalOptima Whole-Child Model program, a **member** who is known to be participating in California's Children Services (CCS) may only enroll in a **health network** that is participating in the Whole-Child Model program.

C. A Health Network Eligible Member who does not select **CCN** or a Health Network shall be subject to the Auto-Assignment process, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

D. CalOptima recognizes that Family Linked Members may be best served by a single Health Network to ensure coordinated delivery of services by a Provider who is knowledgeable about the diverse needs of all of the Members in the family. To facilitate this objective, CalOptima shall assign a Family Linked Member whose family includes a Member already enrolled in a Health Network or **CCN**, to that Health Network or **CCN**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

1. On and after January 1, 2007, except as otherwise provided in this policy, CalOptima shall assign a Family Linked Member to the same Health Network as his or her youngest sibling if such Family Linked Member is under the age of twenty-one (21) years.

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2. If a Family Linked Member is over the age of twenty-one (21) years and his or her youngest sibling is enrolled in CHOC Health Alliance, CalOptima shall assign the Family Linked Member to the Health Network of another family **member**, if applicable.

3. On or after the effective date of the CalOptima Whole-Child Model program, if the **member** is known to be eligible with the Whole-Child Model program/**California Children Services Program (CCS)** and the **member's** youngest sibling is assigned to a **health network** that does not participate in the WCM/**CCS** program, the Family Link process will not apply.

E. A Health Network Eligible Member may change his or her Health Network or select **CCN** for any reason every thirty (30) calendar days, in accordance with this policy.

F. **CCN** or a Health Network shall be responsible for providing Covered Services to its Members, in accordance with its contract and applicable statutes, regulations, CalOptima policies, and other requirements of the CalOptima program.

1. If a Health Network Eligible Member moves outside of Orange County, his or her Health Network shall remain responsible for all Covered Services until the Member is no longer enrolled in the CalOptima program. If a Health Network Eligible Member becomes the responsibility of the Public Administrator/Public Guardian or is in an Institute for Mental Disease and is placed outside of Orange County, his or her Health Network shall continue to be responsible for all Covered Services until the Health Network or the Public Administrator /Public Guardian submits a request to enroll the Member in CalOptima Direct, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

2. If a Member becomes the responsibility of the Foster Care Program, **CCN** or his or her Health Network shall remain responsible for all Covered Services. The Member's foster parent, legal guardian, or the Orange County Children & Family Services Department may request to transition the Member into **CalOptima Direct (COD) – Administrative (COD-A)**, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

G. **CCN** or a Health Network shall not be responsible for Covered Services provided to a Member outside the United States with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22 of the California Code of Regulations, Section 51006.

H. CalOptima or a Health Network shall ensure Continuity **of** Care for Members who transition into CalOptima in accordance with CalOptima Policy GG.1325: Coordination of Care for Members Transitioning into CalOptima Services.

I. In the event that a **member** is required to change **health network**s, due to **health network** termination or participation status of a **health network** in the Whole-Child Model program, CalOptima and the receiving **health network** shall collaborate to coordinate the provision of **covered services** for the affected **member**, in accordance with CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination.

III. PROCEDURE

A. **CCN** or **Health Network** Selection Process

Back to Agenda

1. Upon receipt of the Member's eligibility information from the Department of Health Care Services (DHCS), CalOptima shall send an enrollment packet to a Health Network Eligible Member. The enrollment packet shall include, but not be limited to, the following information:

    a. Introductory/welcome letter;

    b. CalOptima **Health Network** Selection Form;

    c. Health Information Form;

    d. CalOptima **Member** Handbook;

    e. CalOptima **Member** Identification Card;

    f. Invitation to a **Member** orientation;

    g. **Health Network** report card;

    h. **Health Network** Listing and Provider Directory; and

    i. Postage-paid envelope to return materials to CalOptima.

2. Only a Health Network Eligible Member or the Member's Authorized Representative shall sign a Health Network Selection Form on behalf of the Member. CalOptima shall not accept a **Health Network** Selection Form submitted without the signature of the Member or an Authorized Representative.

    a. CalOptima shall not accept responsibility for an inappropriately signed **Health Network** Selection Form.

3. CalOptima realizes that in some instances, such as time-sensitive health care appointments or challenges with valid home addresses, it is in the best interest of the Member to allow a change of Health Network or **CCN** selection request to be made by the Member or the Member's Authorized Representative over the phone in accordance with CalOptima Policy DD.2006b:CalOptima Community Network Member Primary Care Provider Selection/Assignment. In those circumstances, the request will be recorded and processed by the Customer Service Representative at the time of request.

4. If CalOptima receives a Health Network Eligible Member's completed **Health Network** Selection Form by the tenth (10th) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1st) calendar day of the immediately following month. If CalOptima receives a Member's completed **Health Network** Selection Form after the tenth (10th) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1st) calendar day of the month after the immediately following month.

5. A Health Network Eligible Member who has not selected a Health Network or **CCN** within the designated timeframe shall be automatically assigned to a Health Network pursuant to CalOptima Policy AA.1207a: CalOptima Auto-Assignment. Following the assignment of a Member in accordance with this policy, CalOptima shall notify the Member in writing of the assignment.

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6. CalOptima may apply the following criteria to Member assignments to Health Networks or **CCN**:

    a. Consistent with the provisions of this policy and CalOptima Policy AA.1207a: CalOptima Auto-Assignment Policy, CalOptima shall assign Family Linked Members to the same Health Network or **CCN**.

    b. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility less than three hundred sixty-five (365) calendar days, CalOptima shall assign the Health Network Eligible Member to **CCN** or the last Health Network to which the Member was enrolled.

    c. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility more than three hundred sixty-five (365) calendar days, CalOptima shall treat such Health Network Eligible Member as a new Member, in accordance with this policy.

7. If a Health Network contract with CalOptima is terminated, or a health network is no longer participating in the Whole-Child Model Program a **member** who is enrolled in that Health Network may choose a new Health Network or **CCN**, in accordance with this policy.

    a. If the Member does not select a new Health Network or **CCN** prior to the contract termination of the Member's current Health Network, CalOptima shall assign such Member to:

        i. A Health Network of the Member's **PCP**'s choice if the Member's **PCP**, as shown in CalOptima's system, is contracted with at least one (1) other Health Network; or

        ii. A Health Network based on Auto Assignment.

8. A Health Network Eligible Member may change his or her **PCP** every thirty (30) calendar days for any reason

B. **Member**s eligible for enrollment in CHOC Health Alliance

1. Subject to other limitations set forth in this policy, a **member** who meets criteria set forth in Section II.B.2 of this policy may select CHOC Health Alliance.

2. CalOptima shall assign a new Health Network Eligible Member to CHOC Health Alliance, in accordance with Policy AA.1207a: CalOptima Auto-Assignment.

3. Except as otherwise provided in Section III.B.4 of this policy, a 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 the following:

    a. CalOptima shall provide the Member with a ninety (90), sixty (60) and thirty (30) calendar day written notice to select **CCN** or another Health Network prior to the Member's twenty-first (21st) birthday. The written notices shall inform the Member that CHOC will only provide health care service until the end of the Member's twenty-first (21st) birth month.

    b. If the Member does not select **CCN** or another Health Network within the designated timeframe, CalOptima shall assign the Member to **CCN** or a Health Network as follows:

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i. If the Member's **PCP** is contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network of the Member's **PCP**'s choice; or

ii. If the Member's **PCP** is not contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network based on geographic access.

c. The Member shall be enrolled in **CCN** or the new Health Network effective the first (1st) calendar day of the month immediately following the Member's twenty-first (21st) birthday.

4. A Member shall remain in CHOC Health Alliance beyond the Member's twenty-first (21st) birthday if the Member meets all of the following criteria:

a. **Member** is diagnosed with one (1) of the following **California Children's Services (CCS)-**Eligible Conditions:

i. Cystic Fibrosis;

ii. A rare metabolic disorder not including Phenylketonuria (PKU);

iii. Spina Bifida; or

iv. Muscular Dystrophy.

b. **Member** is eligible to receive services from **CCS** for the **CCS**-Eligible Condition as of the day before the Member's twenty-first (21st) birthday; and

c. **Member** is receiving care for the **CCS**-Eligible Condition from a pediatric specialist who is contracted with CHOC Health Alliance as of the day before the Member's twenty-first (21st) birthday.

d. A Member who remains in CHOC Health Alliance pursuant to Section III.B.4.a of this policy shall remain in CHOC Health Alliance until:

i. The Member selects **CCN** or another Health Network; or

ii. The Member's pediatric specialist determines that the Member's care may safely be transitioned to **CCN** or another Health Network.

C. If a Health Network Eligible Member moves outside of Orange County, the Member's Health Network or **CCN** shall continue to be responsible for Covered Services until the Member is no longer enrolled in the CalOptima program.

1. Upon notice that a Health Network Eligible Member has moved outside of Orange County, **CCN** or a Health Network shall attempt to verify this information with the Member. **CCN** or the Health Network shall instruct the Member to contact the County of Orange Social Services Agency or the United States Social Security Administration to report a change of address.

2. A Health Network or **CCN provider** shall notify CalOptima of a Health Network Eligible Member's change of address by submitting a Medi-Cal Contact Information Request Form (MC 354) to the CalOptima Customer Service Department.

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3. Upon notice that a Health Network Eligible Member has moved out of Orange County, CalOptima shall send the Member's new residence information to the County of Orange Social Services Agency, in accordance with Title 22 of the California Code of Regulations, Section 50188, or to the U.S. Social Security Administration.

D. CalOptima recognizes that a situation may occur in which the needs of a Family Linked Member may not be best served by enrollment in the same Health Network as other Members in his or her family in accordance with Section II.D of this policy. A Family Linked Member may contact CalOptima's Customer Service Department to request enrollment in **CCN** or a different Health Network from other Members in his or her family.

IV. ATTACHMENTS

A. Health Network Selection Form
B. CalOptima Introductory Letter

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
E. CalOptima Policy GG.1101: California Children's Services
F. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
G. CalOptima Policy GG.1325: Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima
H. Contract for Health Care Services
I. Medi-Cal Managed Care Division (MMCD) All-Plan Letter (APL) 03-002: SB 87 Medi-Cal Contact Information Release Form
J. Title 22, California Code of Regulations, §§50188, 51006, and 51301 et seq.

VI. REGULATORY AGENCY APPROVALS

A. 11/09/17: Department of Health Care Services
B. 06/24/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
B. 08/07/14: Regular Meeting of the CalOptima Board of Directors
C. 10/03/06: Regular Meeting of the CalOptima Board of Directors
D. 08/30/06: Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	02/20/1997	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	07/01/2004	DD.1114	Request from Members of Same Household to Enroll in Different Health Networks	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2004	DD.1109	Health Network Selection and Health Network Obligations for Members	Medi-Cal
Revised	01/01/2007	DD.2008	Health Network Selection Process	Medi-Cal
Revised	01/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	12/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	03/01/2015	DD.2008	Health Network Selection Process	Medi-Cal
Revised	04/01/2016	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2017	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2018	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal
Revised	04/04/2019	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal

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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.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the members.
CalOptima Direct – Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CCS-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..
Continuity of Care	Services provided to a member rendered by an out-of-network provider with whom the member has pre-existing provider relationship.
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 51310 of Title 22, CCR), which shall be covered for members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Family Linked Member	A member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another member who is in his or her family and who resides in the same household.
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.
Health Network Eligible Member	A member who is eligible to choose a CalOptima health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members.

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.

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PRI-037-105

CalOptima
A Public Agency
Better. Together.

HEALTH NETWORK (HN) SELECTION FORM

MEMBER NAME AND ID #			1 CHOOSE A PRIMARY CARE PROVIDER (PCP)			2 CHOOSE A HN
Last:	First:	ID #:	PCP Last Name or Clinic Name:	PCP First Name:	PCP or Clinic ID:	HN ID*

*Please see your *Health Network Selection Form Guide* for a list of Health Network IDs (HN IDs).
Consulte la *Guía para llenar el Formulario de Selección de Planes de Salud* para una lista de los números de identificación de los planes de salud (HN IDs).
Xin xem *Tài Liệu Hướng Dẫn Điền Mẫu Đơn Chọn Nhóm Y Tế* để biết danh sách Số ID của Các Nhóm Y Tế (Health Network IDs viết tắt là HN IDs).
لطفاً به راهنمای فرم انتخاب شبکه بهداشتی خود برای فهرست شماره شناسایی شبکه های بهداشتی (HN IDs) مراجعه کنید.

3 IMPORTANT! SIGN AND DATE BELOW. THIS FORM MUST BE SIGNED!

Signature of Member or Legal Representative: X _____ Date: _____

Telephone Number: ( ) – Cell Phone Number: ( ) –

E-mail Address:

Do you have insurance other than Medi-Cal / CalOptima? Yes No If Yes, Insurance Name: Policy Number:

NEED HELP? PLEASE CALL CALOPTIMA'S CUSTOMER SERVICE DEPARTMENT AT 1-714-246-8500 OR TOLL-FREE AT 1-888-587-8088

Back to Agenda

Dear Member:

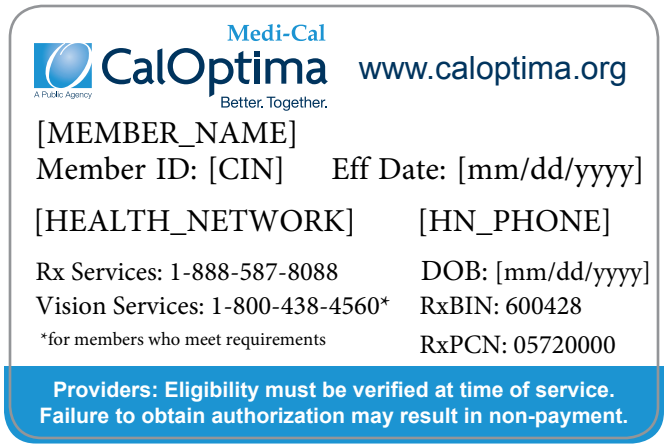
Welcome to CalOptima! CalOptima is the Medi-Cal program for Orange County. CalOptima is responsible for managing your health care benefits.

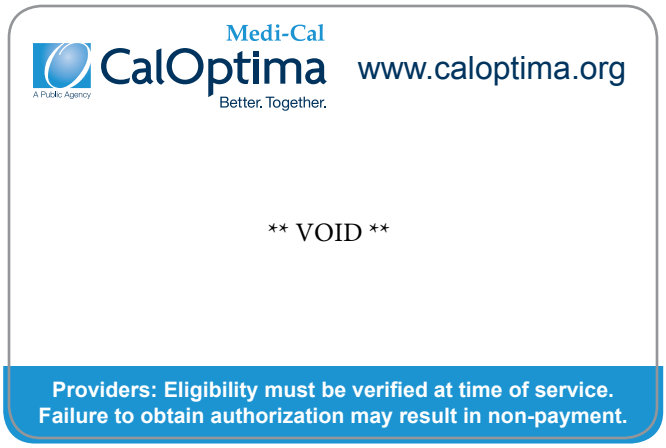
You will receive your Medi-Cal benefits through one of CalOptima's contracted health networks. Please choose a CalOptima health network and a primary care provider (PCP) who is contracted with your health network for each Medi-Cal eligible member of your family. You can choose the same health network for all your family members.

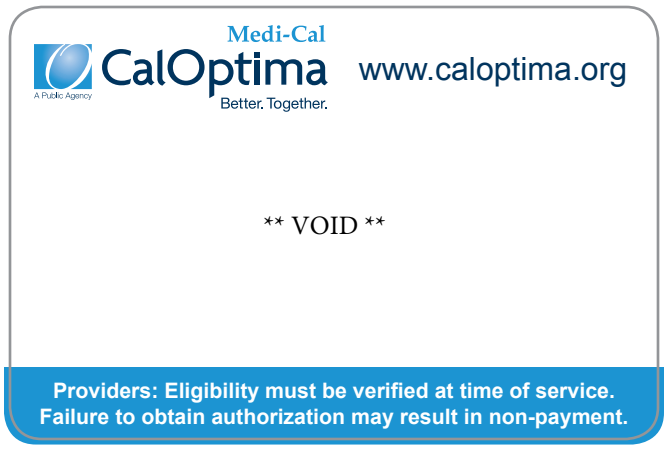
Please use the Health Network Selection Form to choose a health network and PCP for each member of your family. Fill out, sign and return the form to CalOptima as soon as possible. **If you do not choose a health network, CalOptima will choose one for you after 30 days.**

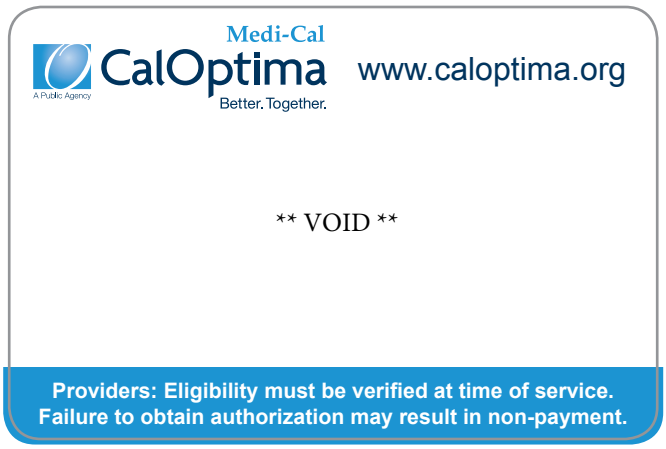
You and your eligible family members may ask to change health networks every 30 days. To do this, you need to complete a Health Network Selection Form. CalOptima has to receive your form by the 10th of the month for your health network change to be effective the 1st of the following month.

If you have questions or need help in choosing a health network, please call CalOptima's Customer Service Department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TTY/TDD users can call **1-800-735-2929**. You can also visit our website at www.caloptima.org.









If you have a life-threatening emergency, call 911 or go to the nearest emergency room. Notify your health network within 24 hours. Emergency services for a true emergency are covered by your health network without prior authorization. Your member handbook has more information on emergency services and how to access your doctor after hours.

For Providers - Member Eligibility Verification:
1-714-246-8540
CalOptima Provider Help Desk:
1-714-246-8600
CalOptima Behavioral Health Line:
1-855-877-3885
TDD/TTY:
1-800-735-2929

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Policy #:	GG.1125
Title:	**Cancer Clinical Trials**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/02
~~Last Review Date:~~	~~08/01/17~~
~~Last~~ Revised Date:	~~08/01/17~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy establishes coverage guidelines for routine health care services provided in connection with a **Member's** participation in a cancer **Clinical Trial**.

II. POLICY

A. CalOptima and its **Health Networks** shall cover routine patient care costs, as defined in Section II.B. of this policy, associated with a **Member's** participation in a Phase I, Phase II, Phase III, or Phase IV cancer **Clinical Trial**, if the **Member** and the cancer **Clinical Trial** meet the requirements set forth herein~~, unless the routine patient care costs are the responsibility of another entity by statute (e.g. California Children's Services (CCS)).~~..

B. Routine patient care costs:

1. Routine patient care costs include health care services that would be:

   a. Provided in the absence of a **Clinical Trial**;

   b. Required for the provision of the investigational drug, item, device, or service;

   c. Required for clinically appropriate monitoring of the cancer treatment;

   d. Provided for the prevention of complications arising from the **Clinical Trial** treatment; or

   e. Needed for reasonable and necessary care arising from complications of the cancer **Clinical Trial**.

2. Routine patient care costs do not include the costs associated with the provision of any of the following:

   a. Drugs or devices that have not been approved by the Federal Drug Administration (FDA) and are associated with the **Clinical Trial**;

   b. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses that a Member may require as a result of treatment being provided for the purposes of the **Clinical Trial**;

   c. Any item or service that is provided solely to satisfy data collection and analysis needs and is not used in the clinical management of the **Member**;

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d. Health care services that, except for the fact that they are being provided in a **Clinical Trial**, are otherwise specifically excluded from coverage under the CalOptima program;

e. Health care services customarily provided by the research sponsors free of charge for any **Member** in the **Clinical Trial**; and

f. Experimental treatment outside of an eligible cancer **Clinical Trial**.

C. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, a **Member** must meet the following requirements:

1. The **Member** must be diagnosed with cancer;

2. The **Member** must be accepted into a Phase I, II, III, or IV **Clinical Trial** for cancer; and

3. The **Member's** treating physician, who is contracted by the **Health Network** to provide health care services, or who participates with CalOptima for a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, must recommend the **Member's** participation in the cancer **Clinical Trial**.

D. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, the cancer **Clinical Trial** must meet the following requirements:

1. The cancer **Clinical Trial** endpoints must not be defined exclusively to test toxicity, or disease pathophysiology, but must have a therapeutic intent;

2. The principal purpose of the cancer **Clinical Trial** is to test whether the intervention potentially improves the **Member's** health outcomes;

3. The cancer **Clinical Trial** is well-supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;

4. The cancer **Clinical Trial** does not unjustifiably duplicate existing studies;

5. The cancer **Clinical Trial** design is appropriate to answer the research question being asked in the **Clinical Trial**;

6. The cancer **Clinical Trial** is sponsored by a credible organization or individual capable of executing the proposed **Clinical Trial** successfully;

7. The cancer **Clinical Trial** is in compliance with Federal regulations relating to the protections of human subjects; and

8. All aspects of the **Clinical Trial** are conducted according to the appropriate standards of scientific integrity.

9. The treatment provided in the cancer **Clinical Trial** must either be:

   a. Approved by one (1) of the following: National Institutes of Health, the FDA, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs; or

   b. Involve a drug that is exempt under federal regulations from a new drug application.

E. CalOptima and its **Health Networks** shall not be prohibited from restricting coverage for routine patient care costs associated with a cancer **Clinical Trial** in California, unless the protocol for the **Clinical Trial** is not provided for at a California hospital or by a California physician.

F. The provision of services as defined under this policy shall not in itself give rise to liability on the part of CalOptima, or the **Health Network**.

G. CalOptima, or a **Health Network**, shall provide care management services to a **Member** who is participating in a cancer **Clinical Trial** to assure that the **Member** is afforded continuity of care, referred to all available resources for his or her illness, and to continue to verify that all eligibility requirements as set forth herein continue to be met.

III. PROCEDURE

A. A Provider~~,~~ or Practitioner~~,~~ shall obtain prior authorization for reimbursement of routine patient care costs related to a **CalOptima Direct** or **CCN Member's** participation in a cancer **Clinical Trial,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

B. A **Provider**, or **Practitioner**, shall obtain prior authorization for reimbursement of routine patient care costs related to a **Health Network Member's** participation in a cancer **Clinical Trial**, in accordance with the policies established by the **Member's Health Network**.

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. DHCS California Children's~~'~~ Services (CCS) Numbered Letter (NL) ~~37-1992~~ 37-1292: Coverage of Experimental and/or Investigational Services
~~C.~~D. CalOptima Health Network Service Agreement
~~D.~~E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~E.~~F. CalOptima Three-Way Agreement with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~F.~~G. Health and Safety Code, §1370.6
~~G.~~H. Medicare National Coverage Determination 100-03, July 9, 2007

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~~H.~~I. Welfare and Institutions Code, §14087.11

VI. REGULATORY AGENCY APPROVALS

A. 02/29/16: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	11/01/2002	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	05/01/2007	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	11/01/2015	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
~~California Children Services (CCS)~~	~~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 (21) years who have CCS Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.~~
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
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.
Clinical Trial	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
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.
Member	An enrollee-beneficiary of a CalOptima program.

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Policy #:	GG.1125
Title:	**Cancer Clinical Trials**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/02
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy establishes coverage guidelines for routine health care services provided in connection with a **Member's** participation in a cancer **Clinical Trial**.

II. POLICY

A. CalOptima and its **Health Networks** shall cover routine patient care costs, as defined in Section II.B. of this policy, associated with a **Member's** participation in a Phase I, Phase II, Phase III, or Phase IV cancer **Clinical Trial**, if the **Member** and the cancer **Clinical Trial** meet the requirements set forth herein..

B. Routine patient care costs:

1. Routine patient care costs include health care services that would be:

   a. Provided in the absence of a **Clinical Trial**;

   b. Required for the provision of the investigational drug, item, device, or service;

   c. Required for clinically appropriate monitoring of the cancer treatment;

   d. Provided for the prevention of complications arising from the **Clinical Trial** treatment; or

   e. Needed for reasonable and necessary care arising from complications of the cancer **Clinical Trial**.

2. Routine patient care costs do not include the costs associated with the provision of any of the following:

   a. Drugs or devices that have not been approved by the Federal Drug Administration (FDA) and are associated with the **Clinical Trial**;

   b. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses that a Member may require as a result of treatment being provided for the purposes of the **Clinical Trial**;

   c. Any item or service that is provided solely to satisfy data collection and analysis needs and is not used in the clinical management of the **Member**;

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d. Health care services that, except for the fact that they are being provided in a **Clinical Trial**, are otherwise specifically excluded from coverage under the CalOptima program;

e. Health care services customarily provided by the research sponsors free of charge for any **Member** in the **Clinical Trial**; and

f. Experimental treatment outside of an eligible cancer **Clinical Trial**.

C. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, a **Member** must meet the following requirements:

1. The **Member** must be diagnosed with cancer;

2. The **Member** must be accepted into a Phase I, II, III, or IV **Clinical Trial** for cancer; and

3. The **Member's** treating physician, who is contracted by the **Health Network** to provide health care services, or who participates with CalOptima for a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, must recommend the **Member's** participation in the cancer **Clinical Trial**.

D. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, the cancer **Clinical Trial** must meet the following requirements:

1. The cancer **Clinical Trial** endpoints must not be defined exclusively to test toxicity, or disease pathophysiology, but must have a therapeutic intent;

2. The principal purpose of the cancer **Clinical Trial** is to test whether the intervention potentially improves the **Member's** health outcomes;

3. The cancer **Clinical Trial** is well-supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;

4. The cancer **Clinical Trial** does not unjustifiably duplicate existing studies;

5. The cancer **Clinical Trial** design is appropriate to answer the research question being asked in the **Clinical Trial**;

6. The cancer **Clinical Trial** is sponsored by a credible organization or individual capable of executing the proposed **Clinical Trial** successfully;

7. The cancer **Clinical Trial** is in compliance with Federal regulations relating to the protections of human subjects; and

8. All aspects of the **Clinical Trial** are conducted according to the appropriate standards of scientific integrity.

9. The treatment provided in the cancer **Clinical Trial** must either be:

a. Approved by one (1) of the following: National Institutes of Health, the FDA, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs; or

b. Involve a drug that is exempt under federal regulations from a new drug application.

E. CalOptima and its **Health Networks** shall not be prohibited from restricting coverage for routine patient care costs associated with a cancer **Clinical Trial** in California, unless the protocol for the **Clinical Trial** is not provided for at a California hospital or by a California physician.

F. The provision of services as defined under this policy shall not in itself give rise to liability on the part of CalOptima, or the **Health Network**.

G. CalOptima, or a **Health Network**, shall provide care management services to a **Member** who is participating in a cancer **Clinical Trial** to assure that the **Member** is afforded continuity of care, referred to all available resources for his or her illness, and to continue to verify that all eligibility requirements as set forth herein continue to be met.

III. PROCEDURE

A. A Provider or Practitioner shall obtain prior authorization for reimbursement of routine patient care costs related to a **CalOptima Direct** or **CCN Member's** participation in a cancer **Clinical Trial,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

B. A **Provider**, or **Practitioner**, shall obtain prior authorization for reimbursement of routine patient care costs related to a **Health Network Member's** participation in a cancer **Clinical Trial**, in accordance with the policies established by the **Member's Health Network**.

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. DHCS California Children's Services (CCS) Numbered Letter (NL) 37-1292: Coverage of Experimental and/or Investigational Services
D. CalOptima Health Network Service Agreement
E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
F. CalOptima Three-Way Agreement with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Health and Safety Code, §1370.6
H. Medicare National Coverage Determination 100-03, July 9, 2007
I. Welfare and Institutions Code, §14087.11

VI. REGULATORY AGENCY APPROVALS

A. 02/29/16: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2002	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	05/01/2007	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	11/01/2015	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
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.
Clinical Trial	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
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.
Member	An enrollee-beneficiary of a CalOptima program.

Policy #:	GG.1515
Title:	**Criteria for Medically Necessary Automobile Orthopedic Positioning Devices**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/1999
~~Last Review Date:~~	~~08/01/17~~
~~Last~~ Revised Date:	~~08/01/17~~04/04/2019

I. PURPOSE

This policy defines the Durable Medical Equipment (DME) guidelines and Medical Necessity criteria for reimbursement of Medically Necessary Automobile Orthopedic Positioning Devices (AOPDs) provided to Members.

II. POLICY

A. An AOPD is a Covered Service under the Whole-Child Model (WCM) program or the CalOptima Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services program when the device meets the criteria and conditions set forth in this policy.

B. Purchase of an AOPD shall require Prior Authorization by CalOptima or the Member's Health Network to be eligible for reimbursement.

C. CalOptima~~,~~ or a Health Network~~,~~ shall provide reimbursement for only one (1) AOPD per Member.

D. A request for reimbursement of an AOPD shall be accompanied by all required documentation.

E. CalOptima~~,~~ or a Health Network~~,~~ shall not authorize the purchase of standard commercially available car seats, vests, or harnesses that are required by California state law for children under six (6) years of age and under sixty (60) pounds.

F. CalOptima~~,~~ or a Health Network~~, shall not~~ will review for Medical Necessity and, if indicated, will authorize the purchase of ~~a Medically Necessary car seat~~an AOPD for children that ~~is otherwise available through the~~are not California ~~Children~~Children's Services ~~Program~~ (CCS~~) or CCS~~)-eligible but require a specially adapted AOPD because of a medical condition under the EPSDT Services program ~~for a Member who is eligible for services through~~.

G. No sooner than the ~~CCS Program~~Department of Health Care Services (DHCS)-approved WCM program effective date, CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for CCS-eligible individuals enrolled in the WCM program, in accordance with CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program.

1. For WCM members, an AOPD shall be evaluated for Medical Necessity in accordance with all current CCS DME Guidelines as provided in CCS Numbered Letters.

III. PROCEDURE

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A. CalOptima and its Health Networks shall utilize the following criteria when determining the Medical Necessity of an AOPD:

1. Car Seats

   a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

   b. Criteria:

      i. The Member shall be over four (4) years of age;

      ii. The Member shall be either over forty (40) pounds, or over forty (40) inches in height; and

      iii. The Member shall meet at least one (1) of the following criteria:

         a) The Member has a moderate to minimal trunk control or sitting ability, moderate to minimal lateral head control, and requires total postural support;

         b) The Member is at risk for breathing complications as a result of poor trunk control or alignment; or

         c) The Member has a skeletal deformity that requires total postural support for safe transportation.

   c. Related Considerations

      i. The Member's height, width, or physical deformity precludes use of a commercially available car seat.

      ii. A harness, or vest, will not provide the Member with enough stability to remain in proper alignment or allow for safe transport.

      iii. The Member cannot be transported in a wheelchair because the family does not own an appropriate vehicle to allow transport in a wheelchair.

2. Harnesses or Vests

   a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

   b. Criteria

      i. The Member shall be over four (4) years of age;

      ii. The Member shall be over forty (40) pounds or over forty (40) inches in height; and

      iii. The Member shall at least one (1) of the following criteria:

         a) The Member has a moderate to minimal trunk control sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment;

c) The Member has a skeletal deformity that requires total postural support for safe transportation; or

d) The Member requires transportation in other than an upright position due to deformity or surgical corrections.

c. Related Considerations

i. The Member's physical deformity or trunk instability precludes use of a standard seat belt or commercially available vest, or harness.

ii. A standard seat belt, or commercially available vest/harness, will not provide the Member with enough stability to remain in proper alignment, or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own appropriate vehicle to allow transport in a wheelchair.

~~B. CalOptima and its Health Networks shall refer medically eligible CCS Members to the CCS program for consideration of AOPD under the EPSDT Service program.~~

~~C.~~B. A request for reimbursement of an AOPD shall be accompanied by:

~~1. A current physician prescription;~~
1. A current prescription provided by the physician of the appropriate specialty for treating the child's condition that the device is intended to address;

a. For children whose CCS-Eligible Condition is the condition necessitating the AOPD, the prescribing physician shall be CCS-paneled.

2. A current medical report that justifies the Medical Necessity of the item requested; and

3. A current physical therapy~~,~~ or occupational therapy, assessment that addresses the criteria as defined in Section III.A. of this policy~~.~~ and includes:

~~D. CalOptima and its Health Networks shall monitor the outcome of CCS referrals for CCS authorization.~~
a. Physical findings;

b. Functional status related to the DME item requested; and

c. A home, school and community accessibility assessment, if indicated.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

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A. California Children's Services Guide for Purchase of Durable Medical Equipment (DME)
B. California Children's Services (CCS) Numbered Letter (NL) 17-1199: Automobile Orthopedic Positioning Devices (AOPDs)
C. California Children's Services (CCS) Numbered Letter (NL) 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
D. California Vehicle Code, §27360
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Policy GG.1101: California Children's Services (CCS) /Whole -Child Model – Coordination with County CCS Program
G. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~98-06~~18-023: California Children Services Whole Child Model Program (supersedes APL 18-011)~~Numbered Letters 01-0298 and 09-0598~~
H. Department of Health Services (DHCS) All Plan Letter (APL) ~~14-017~~18-007: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal ~~Beneficiaries~~Members Under the Age of Twenty-One
I. Title 22, California Code of Regulations (CCR), §§ 51321 and 51160

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	05/01/1999	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	05/01/2007	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	11/01/2015	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	10/01/2016	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	08/01/2017	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	04/04/2019	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal

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IX. GLOSSARY

Term	Definition
Automobile Orthopedic Positioning Devices (AOPDs)	A non-standard positioning device (car sear and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pad that assist in head and truck positioning while being transported in a motor vehicle.
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.
CalOptima	For purposes of this policy, CalOptima shall include both CalOptima Direct and CalOptima Community Network (CCN).
Covered Service	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.
Durable Medical Equipment (DME)	Durable Medical Equipment is any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to an individual in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the patient's home.
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 includes periodic screening that includes at a minimum a comprehensive health and developmental history (including assessment of both physical and mental health development); an unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level taking into account age and risk factors; and health education (including anticipatory guidance), vision, dental, and hearing services. In addition, other necessary health care, diagnostic services, treatment and measures described in Title 42, US Code, Section 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Necessity or Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
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.

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Policy #:	GG.1515
Title:	**Criteria for Medically Necessary Automobile Orthopedic Positioning Devices**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/1999
Revised Date:	04/04/2019

I. PURPOSE

This policy defines the Durable Medical Equipment (DME) guidelines and Medical Necessity criteria for reimbursement of Medically Necessary Automobile Orthopedic Positioning Devices (AOPDs) provided to Members.

II. POLICY

A. An AOPD is a Covered Service under the Whole-Child Model (WCM) program or the CalOptima Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services program when the device meets the criteria and conditions set forth in this policy.

B. Purchase of an AOPD shall require Prior Authorization by CalOptima or the Member's Health Network to be eligible for reimbursement.

C. CalOptima or a Health Network shall provide reimbursement for only one (1) AOPD per Member.

D. A request for reimbursement of an AOPD shall be accompanied by all required documentation.

E. CalOptima or a Health Network shall not authorize the purchase of standard commercially available car seats, vests, or harnesses that are required by California state law for children under six (6) years of age and under sixty (60) pounds.

F. CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for children that are not California Children's Services (CCS)-eligible but require a specially adapted AOPD because of a medical condition under the EPSDT Services program.

G. No sooner than the Department of Health Care Services (DHCS)-approved WCM program effective date, CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for CCS-eligible individuals enrolled in the WCM program, in accordance with CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program.

1. For WCM members, an AOPD shall be evaluated for Medical Necessity in accordance with all current CCS DME Guidelines as provided in CCS Numbered Letters.

III. PROCEDURE

Back to Agenda

A. CalOptima and its Health Networks shall utilize the following criteria when determining the Medical Necessity of an AOPD:

1. Car Seats

a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

b. Criteria:

i. The Member shall be over four (4) years of age;

ii. The Member shall be either over forty (40) pounds, or over forty (40) inches in height; and

iii. The Member shall meet at least one (1) of the following criteria:

a) The Member has a moderate to minimal trunk control or sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment; or

c) The Member has a skeletal deformity that requires total postural support for safe transportation.

c. Related Considerations

i. The Member's height, width, or physical deformity precludes use of a commercially available car seat.

ii. A harness, or vest, will not provide the Member with enough stability to remain in proper alignment or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own an appropriate vehicle to allow transport in a wheelchair.

2. Harnesses or Vests

a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

b. Criteria

i. The Member shall be over four (4) years of age;

ii. The Member shall be over forty (40) pounds or over forty (40) inches in height; and

iii. The Member shall at least one (1) of the following criteria:

a) The Member has a moderate to minimal trunk control sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment;

c) The Member has a skeletal deformity that requires total postural support for safe transportation; or

d) The Member requires transportation in other than an upright position due to deformity or surgical corrections.

c. Related Considerations

i. The Member's physical deformity or trunk instability precludes use of a standard seat belt or commercially available vest, or harness.

ii. A standard seat belt, or commercially available vest/harness, will not provide the Member with enough stability to remain in proper alignment, or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own appropriate vehicle to allow transport in a wheelchair.

B. A request for reimbursement of an AOPD shall be accompanied by:

1. A current prescription provided by the physician of the appropriate specialty for treating the child's condition that the device is intended to address;

a. For children whose CCS-Eligible Condition is the condition necessitating the AOPD, the prescribing physician shall be CCS-paneled.

2. A current medical report that justifies the Medical Necessity of the item requested; and

3. A current physical therapy or occupational therapy, assessment that addresses the criteria as defined in Section III.A. of this policy and includes:

a. Physical findings;

b. Functional status related to the DME item requested; and

c. A home, school and community accessibility assessment, if indicated.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. California Children's Services Guide for Purchase of Durable Medical Equipment (DME)
B. California Children's Services (CCS) Numbered Letter (NL) 17-1199: Automobile Orthopedic Positioning Devices (AOPDs)
C. California Children's Services (CCS) Numbered Letter (NL) 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
D. California Vehicle Code, §27360

E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-023: California Children Services Whole Child Model Program (supersedes APL 18-011)
H. Department of Health Services (DHCS) All Plan Letter (APL) 18-007: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of Twenty-One
I. Title 22, California Code of Regulations (CCR), §§ 51321 and 51160

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/1999	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	05/01/2007	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	11/01/2015	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	10/01/2016	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	08/01/2017	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	04/04/2019	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal

IX. GLOSSARY

Term	Definition
Automobile Orthopedic Positioning Devices (AOPDs)	A non-standard positioning device (car sear and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pad that assist in head and truck positioning while being transported in a motor vehicle.
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.
CalOptima	For purposes of this policy, CalOptima shall include both CalOptima Direct and CalOptima Community Network (CCN).
Covered Service	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.
Durable Medical Equipment (DME)	Durable Medical Equipment is any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to an individual in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the patient's home.
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 includes periodic screening that includes at a minimum a comprehensive health and developmental history (including assessment of both physical and mental health development); an unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level taking into account age and risk factors; and health education (including anticipatory guidance), vision, dental, and hearing services. In addition, other necessary health care, diagnostic services, treatment and measures described in Title 42, US Code, Section 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Necessity or Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
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.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

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Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

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WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

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4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

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

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

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integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

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Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

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While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

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To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

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Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

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Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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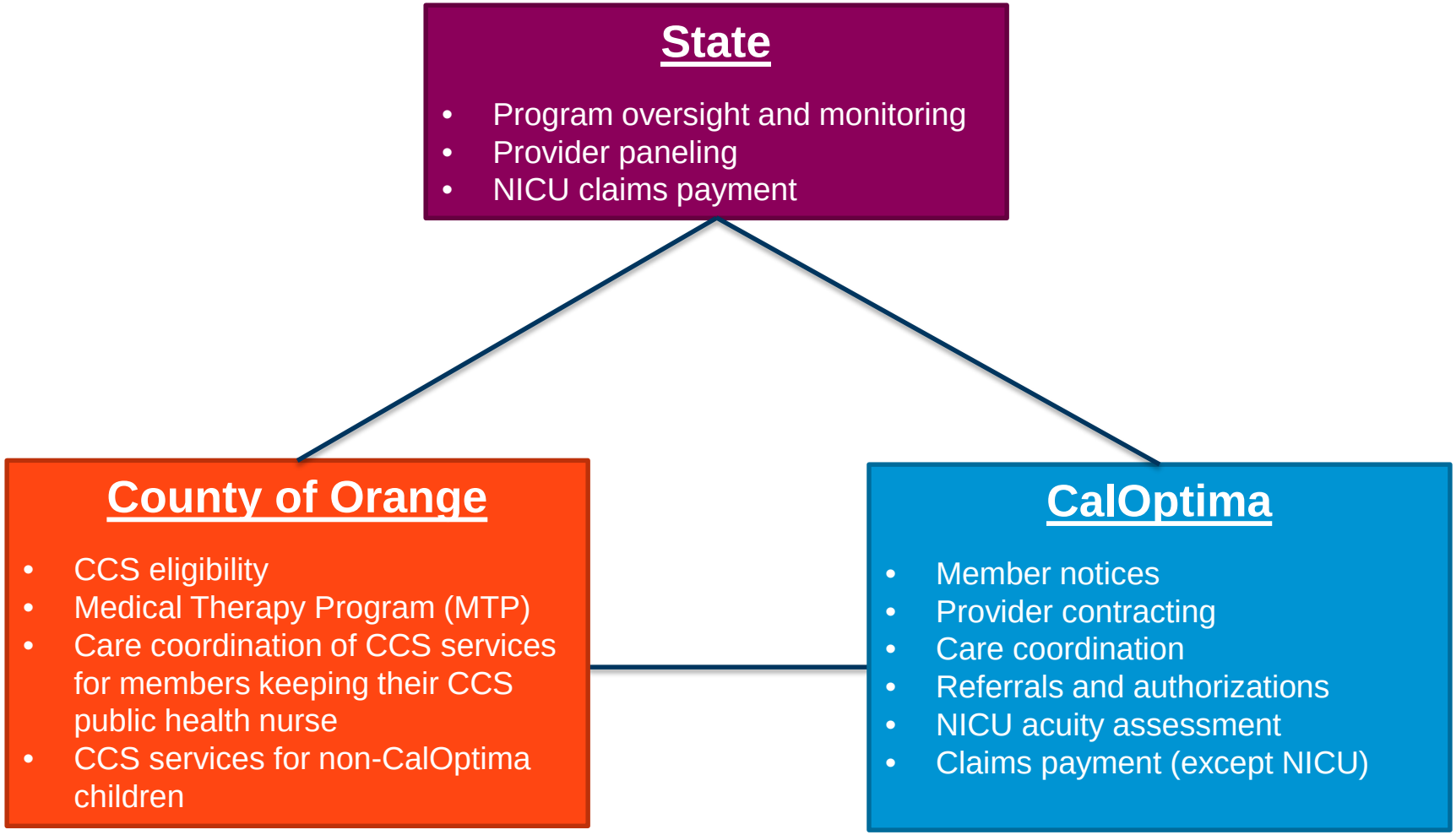
Background

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Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

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Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

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- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

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The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

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Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader — **Authorized Signature**

10/23/2017 — **Date**

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RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

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and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

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The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

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1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

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2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

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1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

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a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

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None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

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IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

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Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

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Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

CalOptima
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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

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3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

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Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES 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. This APL supersedes APL 18-011.

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]

[1] CCS N.L.s can be found at: https://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). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), 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 continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning 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 – Implemented 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	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed 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 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

[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

determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical 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, 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). WCM counties participating with the MTP will continue to receive a separate allocation for this program and are responsible for care coordination of MTP services.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices. Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[6]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/Pediatric Intensive Care Unit/Neonatal Intensive Care Unit (NICU)

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, as well as all 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,

[6] See the WCM CCS N.L. Category List. is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Index-Category-List-June2018.xls

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 serves as the primary vehicle for ensuring 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. The MOU must include, at a minimum, all of the provisions specified in the MOU template and must be consistent with the requirements of SB 586. MCPs are required to submit an executed MOU to DHCS 105 days prior to implementation. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS members 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, including administrative functions, from the county CCS program to the MCPs.[8] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensuring C.O.C. and services for members who are 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 the Children's Medical Services Net (CMS Net) system 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 C.O.C. of already approved service authorization requests, as required by this APL and applicable state and federal laws.

[7] See footnote 5. The MOU template can be found on the CCS WCM website.
[8] See footnote 4. WIC Section 14094.7(d)(4)(C).

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When a CCS-eligible member moves from one county to another, 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 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 must communicate all resolved disputes in writing to the MCP. 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 CCSRedesign@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 must assess each CCS member'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 removes or limits existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

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[9] See footnote 4. WIC Section 14093.06(b).
[10] Unresolved disputes must be referred to: CCSRedesign@dhcs.ca.gov
[11] See footnote 4. WIC Section 14094.15(d).

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 CCS members enrolling in the MCP, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level through:

   - 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 who 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, as described below:

   <u>New Members and Newly CCS-Eligible Members Determined High Risk</u>
   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.

   <u>Risk Assessment</u>
   The risk assessment process must address:

   - 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;

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- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a 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 identify 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 to be 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, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- 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.

[12] See footnote 4. WIC Section 14094.11(b)(4).

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The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must 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 must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- 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; and
- 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 members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of 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 members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

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 members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a 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 a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[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 must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to 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:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] 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 C.O.C. 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 member's 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 who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

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 member. The MCPs must provide care coordination to 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.

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[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 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. 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 DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- 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. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. 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 an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with 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. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their 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.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

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D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS 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

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] 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 the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. 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. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

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

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

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centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] 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.[34]

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 FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet 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: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

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IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] 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.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] 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
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. 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:[41]

- 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; and
- Procedures to detect both under- and over-utilization of health care services.

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 format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. 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 companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] 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

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. 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 the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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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

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redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

[8] See WIC Section 14094.7(d)(4)(C), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&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.

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[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&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;

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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.

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[24] See APL 17-006, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf
[25] See APL 17-006
[26] See CCS N.L. 03-0810, which is available at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[27] APL 17-010 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf

F. Out-of-Network Access

MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.[28] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[29] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[30]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS fee-for-service rates, unless the provider and the MCP enter into

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[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

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CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-Out: Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity	MCP	MCP	DHCS

IV. MCP Responsibilities to DHCS

A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

approval status.[34] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[38]

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

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[34] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

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

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES 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. This APL supersedes APL 18-011.

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]

[1] CCS N.L.s can be found at: https://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). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), 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 continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning 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 – Implemented 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	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed 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 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

[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

determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical 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, 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). WCM counties participating with the MTP will continue to receive a separate allocation for this program and are responsible for care coordination of MTP services.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices. Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[6]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/Pediatric Intensive Care Unit/Neonatal Intensive Care Unit (NICU)

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, as well as all 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,

[6] See the WCM CCS N.L. Category List. is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Index-Category-List-June2018.xls

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 serves as the primary vehicle for ensuring 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. The MOU must include, at a minimum, all of the provisions specified in the MOU template and must be consistent with the requirements of SB 586. MCPs are required to submit an executed MOU to DHCS 105 days prior to implementation. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS members 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, including administrative functions, from the county CCS program to the MCPs.[8] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensuring C.O.C. and services for members who are 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 the Children's Medical Services Net (CMS Net) system 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 C.O.C. of already approved service authorization requests, as required by this APL and applicable state and federal laws.

[7] See footnote 5. The MOU template can be found on the CCS WCM website.
[8] See footnote 4. WIC Section 14094.7(d)(4)(C).

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When a CCS-eligible member moves from one county to another, 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 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 must communicate all resolved disputes in writing to the MCP. 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 CCSRedesign@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 must assess each CCS member'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 removes or limits existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

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[9] See footnote 4. WIC Section 14093.06(b).
[10] Unresolved disputes must be referred to: CCSRedesign@dhcs.ca.gov
[11] See footnote 4. WIC Section 14094.15(d).

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 CCS members enrolling in the MCP, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level through:

   - 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 who 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, as described below:

   <u>New Members and Newly CCS-Eligible Members Determined High Risk</u>
   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.

   <u>Risk Assessment</u>
   The risk assessment process must address:

   - 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;

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- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a 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 identify 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 to be 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, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- 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.

[12] See footnote 4. WIC Section 14094.11(b)(4).

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The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must 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 must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- 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; and
- 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 members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of 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 members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

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 members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a 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 a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[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 must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to 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:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] 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 C.O.C. 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 member's 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 who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

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 member. The MCPs must provide care coordination to 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.

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[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 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. 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 DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- 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. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. 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 an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with 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. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their 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.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

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D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS 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

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] 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 the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. 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. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

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

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

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centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] 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.[34]

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 FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet 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: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

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IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] 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.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] 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
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. 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:[41]

- 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; and
- Procedures to detect both under- and over-utilization of health care services.

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 format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. 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 companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] 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

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. 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 the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES 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. This APL supersedes APL 18-011.

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]

[1] CCS N.L.s can be found at: https://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). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), 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 continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning 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 – Implemented 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	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed 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 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

[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

determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical 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, 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). WCM counties participating with the MTP will continue to receive a separate allocation for this program and are responsible for care coordination of MTP services.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices. Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[6]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/Pediatric Intensive Care Unit/Neonatal Intensive Care Unit (NICU)

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, as well as all 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,

[6] See the WCM CCS N.L. Category List. is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Index-Category-List-June2018.xls

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 serves as the primary vehicle for ensuring 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. The MOU must include, at a minimum, all of the provisions specified in the MOU template and must be consistent with the requirements of SB 586. MCPs are required to submit an executed MOU to DHCS 105 days prior to implementation. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS members 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, including administrative functions, from the county CCS program to the MCPs.[8] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensuring C.O.C. and services for members who are 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 the Children's Medical Services Net (CMS Net) system 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 C.O.C. of already approved service authorization requests, as required by this APL and applicable state and federal laws.

[7] See footnote 5. The MOU template can be found on the CCS WCM website.
[8] See footnote 4. WIC Section 14094.7(d)(4)(C).

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When a CCS-eligible member moves from one county to another, 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 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 must communicate all resolved disputes in writing to the MCP. 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 CCSRedesign@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 must assess each CCS member'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 removes or limits existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

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[9] See footnote 4. WIC Section 14093.06(b).
[10] Unresolved disputes must be referred to: CCSRedesign@dhcs.ca.gov
[11] See footnote 4. WIC Section 14094.15(d).

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 CCS members enrolling in the MCP, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level through:

   - 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 who 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, as described below:

   <u>New Members and Newly CCS-Eligible Members Determined High Risk</u>
   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.

   <u>Risk Assessment</u>
   The risk assessment process must address:

   - 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;

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- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a 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 identify 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 to be 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, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- 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.

[12] See footnote 4. WIC Section 14094.11(b)(4).

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The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must 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 must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- 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; and
- 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 members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of 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 members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

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 members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a 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 a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[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 must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to 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:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] 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 C.O.C. 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 member's 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 who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

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 member. The MCPs must provide care coordination to 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.

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[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 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. 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 DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- 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. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. 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 an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with 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. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their 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.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

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D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS 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

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] 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 the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. 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. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

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

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

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centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] 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.[34]

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 FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet 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: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

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IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] 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.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] 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
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. 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:[41]

- 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; and
- Procedures to detect both under- and over-utilization of health care services.

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 format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. 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 companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] 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

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. 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 the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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Whole Child Model Network Certification Requirements for Delegated Entities

Managed care health plans (MCPs) and their delegated entities (DEs) are required to meet specific network certification requirements in order to participate in Whole Child Model. The requirements include 27 network certification components: 24 core specialists, tertiary and pediatric community hospitals, and NICUs by either meeting the required overlap threshold or having a contract with at least 1 of that provider/specialty type or facility statewide.

DEs are responsible for meeting the overlap threshold for 23 of the 27 components. For the remaining four components listed below, MCPs will be required to meet the statewide requirement of a minimum of 1 of each provider/subspecialty type due to the rarity of the subspecialists statewide. Approved DEs will be allowed to participate in WCM while continuing to seek contractual relationships with the following:

- Pediatric Dermatology *(23 statewide)*
- Pediatric Developmental and Behavioral Medicine *(5 statewide)*
- Oral and Maxillofacial Surgery *(20 statewide)*
- Transplant Hepatology *(6 statewide)*

DEs must allow out of network access to any and all specialists required to cover medically necessary CCS services, including but not limited to, the specialists listed above. This includes subspecialists not included as part of the WCM network certification. Although DEs are not required to have the 4 rare subspecialists for the WCM network certification in order to participate at implementation, DEs are encouraged to continue contracting efforts.

The certification results of DEs are grouped into two categories:

% of WCM Certification Requirements Met	# of Deficiencies	Met/Not Met
95% - 100%	0-1	Met
Below 95%	2 or more	Not Met[1]

WCM MCP's Overall Provider Network

DEs that do not meet WCM Network Certification components will not be included in WCM MCP's overall provider network assessment. In order for a WCM MCP to be approved for WCM, they must continue to meet required WCM Network Certification components using only CCS-paneled providers contracted with DEs that are able to participate.

DEs Meeting WCM Requirements

For a DE to be approved for WCM, the DE must have executed contracts with 95% of the 23 components. The remaining DEs that have greater deficiencies are deemed as "Not Met" for certification purposes. DHCS may consider allowing DEs that do not meet requirements (below 95%) if they can attest that 95% of the certification requirements are met by January 2, 2019. MCPs will be required to demonstrate that DEs are compliant with network certification requirements by submitting contract signature pages by March 1, 2019.

If an MCP has a direct network, DHCS will permit an MCP to subcontract with one DE using their direct network to bring one additional DE into compliance with network certification standards.

DHCS will provide the MCP with formal notification by March 15, 2019 of DEs that DHCS will approve in the certification process for the Phase 3 WCM implementation. If an MCP's DE is approved on March 15, 2019 and is 95% compliant with WCM network certification requirements, a CAP will be imposed beginning July 1, 2019 until the

[1] MCP will have 30 days to finalize contract negotiations to remedy their deficiencies to potentially move them into the 95% and meet certification requirements

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MCP can demonstrate that the DE is 100% complaint with WCM network certification requirements. Additional information on the CAP requirements and process are below.

DEs Not Meeting WCM Requirements

DEs that do not meet WCM network certification requirements will be excluded from operating in WCM until they are able to demonstrate they meet the WCM network certification requirements. CCS-eligible members enrolled in DEs that are found ineligible to participate in WCM will be given the option to select a new DE or be reassigned to DEs that meet 100% of the WCM network certification requirements. The WCM MCP will be required to update their auto-assignment P&P and algorithm to distribute CCS-eligible members equally amongst DEs that meet all requirements. The MCP will also be required to send a DHCS approved member notice to members assigned to DEs that do not meet WCM network certification standards at least 90 days prior to July 1, 2019.

In accordance with Network Certification Requirements APL 18-005, WCM MCPs may request to add a DE to their WCM network 105 days prior to the start of each contract year (no sooner than September petition date for a January 1, 2020 WCM implementation).

Access for CCS-eligible Members Outside of DE

Members must be allowed to receive services for their CCS condition outside of their assigned DE for continuity of care (COC) purposes or if there no providers that meet the member's CCS medical needs within the DE's network. Members who are required to select or be reassigned to a new DE that is approved to participate in WCM are permitted through COC to continue to receive services from a provider in their previous DE, including their assigned PCP. The WCM MCP and DEs must comply with COC requirements outlined in APL 18-008[2].

Corrective Action Plan (CAP) and CAP Mandates

WCM MCPs that have DEs that are approved to participate in WCM but have outstanding network deficiencies upon implementation would be placed under a CAP. The WCM MCP will have until March 15, 2019 to demonstrate DEs approved to participate in WCM have met 100% of WCM certification requirements. The DE would have 6 months from July 1, 2019 to remedy the network deficiency by contracting with the appropriate CCS-paneled provider. While under the CAP, the DEs must allow WCM members to access WCM services outside of the DE network until DHCS finds that the deficiency has been corrected.

Additional MCP Requirements

WCM MCPs that have DEs will be required to submit additional documentation to DHCS for review and/or approval:

1. CCS-paneled Provider Network for DEs.
2. Attestation stating CCS-eligible members will not be assigned to a DE that is excluded from participating in WCM.
3. WCM MCP oversight and readiness activities for DEs to demonstrate requirements are met for implementation.
4. Auto-assignment process and algorithm for CCS-eligible members who are assigned to a new DE.
5. Member notice outlining that they must select a new DE or they will be assigned to an approved DHCS DE.
6. Updated Policies and Procedures
    a. DE monitoring
    b. Continuity of Care

[2] APL 18-008 can be found here: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-008.pdf

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Phase 3 Network Certification Recommendations

CalOptima

CalOptima's DEs Networks

Based on WCM network certification results, DHCS' preliminary assessment approves the WCM provider networks for the following DEs that met 95% or more of the WCM network certification requirements:

Requirements Met - 95% and above		
DE	**# of Deficiencies**	**Provider Type**
1. CalOptima Community	0	N/A
2. Children's Hospital of Orange County (CHOC)	0	N/A
3. Kaiser Permanente	0	N/A
4. Talbert Medical Group	0	N/A
5. AltaMed	0	N/A
6. Arta Western	1	Physical Medicine and Rehabilitation
7. Monarch Family	1	Rheumatology
Requirements Not Met – Below 95%		
DE	**# of Deficiencies**	**Provider Types**
8. Regal Medical Group	2	Infectious Disease; Neurology
9. Noble	2	Infectious Disease; Neurology
10. United Care Medical Group	3	Physical Medicine and Rehabilitation; Plastic Surgery; Rheumatology
11. Prospect Medical Group	4	Genetics; Infectious Disease; Plastic Surgery; Rheumatology
12. Family Choice	8	Allergy and Immunology; Endocrinology; Genetics; Infectious Disease; Neurology; Physical Medicine and Rehabilitation; Rheumatology; Urology
13. AMVI Care	9	Genetics; Hematology-Oncology; Infectious Disease; Neurology; Neurological Surgery; Physical Medicine and Rehabilitation; Plastic Surgery; Pulmonology; Rheumatology

CalOptima's DE Hospital Network

Health Network	Contract Model
AltaMed Health Services Corporation	SRG
AMVI Care Health Network	PHC
Arta Western Medical Group, Inc.	SRG
CHOC Health Alliance	PHC
Family Choice Health Network	PHC
Heritage Provider Network (HPN) - Regal Medical Group	HMO
Kaiser Permanente	HMO
Monarch Family HealthCare	HMO
Noble Mid-Orange County	SRG
Prospect Medical Group	HMO
Talbert Medical Group, Inc.	SRG
United Care Medical Group, Inc	SRG

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Contract Model	Inpatient Contract Holder	Inpatient Payer	Inpatient Payment Structure
HMO	DE	DE	Capitated
PHC	Delegated Hospital*	Delegated Hospital*	Capitated
SRG	CalOptima	CalOptima	FFS

* In the PHC model, CalOptima delegates institutional risk to a delegated hospital and professional risk to a delegated provider group (which we have been referring to as “Health Networks” or “Delegated Entities”). In the PHC arrangement, CalOptima pays the delegated hospital capitation, which the delegated hospital uses to pay for institutional services provided to a given member, whether that care is rendered by the delegated hospital itself or by another facility with which it is contracted. In the PHC arrangement, CalOptima separately pays the delegated provider group capitation, which it uses to pay for professional services provided to a given member. In the PHC arrangement, the delegated provider group performs utilization management for the group’s assigned members, whether the member requires institutional or professional services. A contract also exists between the delegated hospital and the delegated provider group, and that contract contains a risk sharing element.

CalOptima’s Overall Provider Network

CalOptima meets the WCM network certification overlap requirements[3] as an “overall network” using the 7 DEs that are meeting the WCM certification. The Oral and Maxillofacial Surgery Specialist was also included in the “overall network” assessment although there is only one provider within the county and the provider is currently contracted with Kaiser exclusively. CalOptima Community is in contract negotiations with 5 Cleft Palate SCCs that have Oral and Maxillofacial Surgery Specialists.

[3] Each WCM MCP is required to meet 50% in-county, 25% regionally, 10% statewide or contract with at least one for each component included in the certification.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

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- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

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	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

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A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II. HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III. HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in at least one of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to

be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

Acuity Eligibility Criteria

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above.

MCPs must have a process to verify eligibility as part of their internal TEL production and enrollment process. MCPs can do this through reviews of the MCPs data, to the extent that data is available, and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

The TEL provides a list of potentially eligible members. MCPs may use this file in several ways. Examples include:

1. After applying the DHCS approved MCP prioritization policy to the TEL, the MCP may directly assign members on the TEL to CB-CMEs. In this scenario, the MCP delegates eligibility verification to the CB-CMEs.

2. MCPs may use their own data to develop eligibility lists, adding members from the TEL who qualify through their SMI or Physical Health/SUD chronic condition diagnoses for whom the MCP may lack utilization data.

MCPs may also use other strategies approved by DHCS. In all cases, MCPs must ensure that the approved MCP prioritization logic is applied to all assigned members to guide MCP and/or CB-CME outreach.

MCPs are advised to deprioritize members from outreach whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions.

For payment purposes, the member may be enrolled for one month while eligibility is verified. After one month, payment is not available until eligibility is determined. If determined ineligible, the member will be disenrolled.

Homeless Eligibility Criteria

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section*

50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her residence." For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

People Excluded from Targeted Engagement List

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
    1) Engage the member in the HHP and their own care
    2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
    3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
    4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
    1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
    2) How trauma-informed care best practices will be utilized?
    3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
    1) How the HAP is shared with other providers and if it can be shared electronically; and
    2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
    1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
    2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support

- Working with the member to implement their HAP
- Assisting the member in navigating health, behavioral health, and social services systems, including housing
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Identifying barriers to the member's treatment and medication management adherence
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Assisting in attainment of the member's goals as described in the HAP
- Encouraging the member's decision making and continued participation in HHP
- Accompanying members to appointments as needed

2) Coordination

- Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
- Creating and promoting linkages to other services and supports
- Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
    i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
    ii. Tier 1 – two in-person visits per month
    iii. Tier 2 – 1 in-person visit per month
    iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V. Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.
f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.
g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.
h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.
i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.
b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies
b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers
c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges
d. Track and share data with CB-CMEs regarding each member's health history
e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of

the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:
      a. Letter to member followed by phone call to member
      b. Phone call to member, outreach to care delivery partners and social service partners

c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity

for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;

- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities. The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members

must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

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- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

SAMPLE

B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or
3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or
3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or
3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

- Nursing Facility Residents
- Hospice Recipients
- Members with TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or AHF
- Members in Cal MediConnect

b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

- Dually eligible members
- Members in CCS or GHPP
- Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Filler	Filler	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Filler	Filler	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

D. Appendix D – Readiness Requirements and Checklist

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI– MHP-MOU: Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

SMI Network: Section III – Network (Deliverables #6.2a and 6.2b)

Group 1: San Francisco Counties

Deliverable Due Dates		Deliverable Approval Dates
P&Ps:	3/1/18	5/1/18
Network:	5/1/18	6/1/18
SMI Deliverables:	11/1/18	12/1/18

Group 2: Riverside, and San Bernardino Counties

Deliverable Due Dates		Deliverable Approval Dates
Network:	11/1/18	12/1/18
SMI MHP-MOU:	2/1/19	3/1/19
SMI Network:	5/1/19	6/1/19

Group 3.1: Imperial, and Santa Clara Counties

Deliverable Due Dates		Deliverable Approval Dates
Network:	4/1/19	6/1/19
SMI MHP-MOU:	7/1/19	8/1/19
SMI Network:	10/1/19	12/1/19

Group 3.2: Alameda, Kern, Los Angeles, Sacramento, San Diego, and Tulare Counties

Deliverable Due Dates		Deliverable Approval Dates
Network:	5/1/19	6/1/19
SMI MHP-MOU:	8/1/19	9/1/19
SMI Network:	11/1/19	12/1/19

Group 4: Orange County

Deliverable Due Dates		Deliverable Approval Dates
Network:	11/1/19	12/1/19
SMI MHP-MOU:	2/1/20	3/1/20
SMI Network:	5/1/20	6/1/20

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.

For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.

When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.

- Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

4.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

4.2 Submit the Health Action Plan (HAP) template.

4.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:

- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

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III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – SMI**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members

with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

□ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

□ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

□ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

□ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

□ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

□ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

□ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

□ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

Managed Care Plan	Signature of Authorized Representative
Date	Name of Authorized Representative
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	**HCPCS Code**	**Modifier**	**Units of Service (UOS)**
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Telehealth and Group Visits

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

F. Appendix F – Evidence of Coverage Template

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Do not make changes to this template. Reports that contain changes to this template will be rejected and must be resubmitted.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2– April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4– October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example:

MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

All report revisions are subject to DHCS review and approval.

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx.to your designated folder in the "DHCS-MCQMD-Data/MCP/Monitoring" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Homeless and Chronically Homeless: see CA Welfare & Institution Code § 14127(e)

Housing Services:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. **For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information**.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

1. Health Home Program Enrollment Reporting
Note: **Only report one (1) exclusionary reason per member excluded from the Program.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Column Name	Explanation
Number MCP excluded because not eligible - well-managed (Column C)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.
Number MCP excluded because declined to participate (Column D)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP.
Number MCP excluded because of unsuccessful engagement (Column E)	Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment.

Column Name	Explanation
Number MCP excluded because duplicative program (Column F)	Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following: 1. Duplicative Programs a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH) b. Targeted Case Management (TCM) – County, not Mental Health TCM 2. Programs excluded by DHCS Policy a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month. b. Hospice 3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy
Number MCP excluded because unsafe behavior or environment (Column G)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

Column Name	Explanation
Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)	Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following: a. Fee-For-Service b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF) c. Member is deceased
Number externally referred but excluded (Column I)	Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H.
Average monthly number of dedicated care coordination FTEs (Column J)	Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number.

2. Health Home Program Member Activity Reporting

Column Name	Explanation
Plan Code – Plan Name – County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
Number initial HAP completed within 90 days (Column C)	Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment.
Number initial HAP completed (Column D)	Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter.

3. Health Home Program Member-Level Detail Reporting
Note: This tab captures all members enrolled in HHP. Additionally, this tab reports on those members who are homeless/at risk of homelessness and received housing support services during the quarter. If a member was disenrolled during the quarter, enter the disenrollment date. The disenrolled member should not be reported in subsequent quarters unless the member reenrolls. This tab is to be submitted quarterly.

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported. For example, the 4th quarter of 2019 will be entered as 2019 Q4.
Member CIN (Column C)	Enter the Member's Client Identification Number (CIN).
Member Last Name (Column D)	Enter the Member's Last Name.
Member First Name (Column E)	Enter the Member's First Name.
Member Date of Birth (DOB) (Column F)	Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY.
SPA 1 (PHYS-SUD) or SPA 2 (SMI) Member (Column G)	Indicate which State Plan Amendment (SPA) the HHP member was enrolled under. Enter "1" or "2."
Dual Member (Column H)	Indicate the member's "Dual" status (having both Medicare & Medi-Cal) as of the last day of the quarter. If the member was disenrolled during the quarter, report as of their last date of enrollment. Enter "Dual" or "Non-Dual."
Externally Referred and Enrolled (Column I)	Indicate whether the HHP enrolled member was referred into the program. Enter "Yes" or "No." The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Indicate "Yes" if, upon MCP review and evaluation, the individual is approved for HHP and enrolled.

Column Name	Explanation
Enrollment Date (Column J)	Enter the Member's Enrollment Date using format MM/DD/YY.
Date of Disenrollment (if applicable) (Column K)	Enter the Member's Date of Disenrollment using format MM/DD/YY. If the Member remains enrolled in the program, leave this cell blank. The disenrolled member should not be reported in subsequent reports unless the member reenrolls.
Member was Homeless or at Risk for Homelessness During The Quarter(Column L)	Indicate whether the member met the Federal definition of Homeless or required tenancy sustaining services at any point during the quarter. Enter “Yes" or "No."
Member Received Housing Services During the Quarter (Column M)	Indicate whether the member received housing services at any point during the quarter. Enter "Yes" or "No."
Member was Homeless At Any Point During Their Enrollment in HHP (Column N)	Indicate whether the member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No."
Members no longer Homeless On Last Day of the Quarter (Column O)	Indicate whether the member no longer meets the Federal definition of Homeless as of the last day of the quarter. If the member was disenrolled during the quarter, report as of their last date of enrollment. Enter "Yes" or "No." Leave Blank if the member was never Homeless.

4. Health Home Program Network Reporting

Column Name	Explanation
Plan Code – Plan Name – County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member’s assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
CB-CME NPI # (Column C)	Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for

Column Name	Explanation
	that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors.
Capacity for each CB-CME (Column D)	Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter.

5. Health Home Program Annual CMS Core Measures Reporting

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. The first annual quality reporting for the CBP measure will begin in Measurement Year (MY) 2020 and will be submitted in Reporting Year (RY) 2021 with the Q1 Report, due May 31, 2021. There is no partial-year reporting for the Health Homes Core Set of Health Care Quality Measures.

DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the following Technical Specifications and Resource Manual link from CMS.

https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/FFY-19-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

Note: **This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year for the data reported: Year.
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 -	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator

Column Name	Explanation
numerator (Column M)	
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator

6. Health Home Program Reporting Comments

Column Name	Explanation
Comments (Column A)	Enter any relevant information pertaining to the submitted report and the data it contains.

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41

HHP Eligible Condition Diagnosis Codes

Hypertension
I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,
Liver Disease
K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4
TBI
S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

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S14.115S, S14.116S, S14.117S, S14.118S, S14.119S, S14.121S, S14.122S, S14.123S, S14.124S, S14.125S, S14.126S, S14.127S, S14.128S, S14.129S, S14.131S, S14.132S, S14.133S, S14.134S, S14.135S, S14.136S, S14.137S, S14.138S, S14.139S, S14.141S, S14.142S, S14.143S, S14.144S, S14.145S, S14.147S, S14.148S, S14.149S, S14.151S, S14.152S, S14.153S, S14.154S, S14.155S, S14.156S, S14.157S, S14.158S, S14.159S, S14.2XXS, S14.3XXS, S14.4XXS, S14.5XXS, S14.8XXS, S14.9XXS, S24.0XXS, S24.101S, S24.102S, S24.103S, S24.104S, S24.109S, S24.111S, S24.112S, S24.113S, S24.114S, S24.119S, S24.131S, S24.132S, S24.133S, S24.134S, S24.139S, S24.141S, S24.142S, S24.144S, S24.149S, S24.151S, S24.152S, S24.153S, S24.154S, S24.159S, S24.2XXS, S24.3XXS, S24.4XXS, S24.8XXS, S24.9XXS, S34.01XS, S34.02XS, S34.101S, S34.102S, S34.103S, S34.104S, S34.105S, S34.109S, S34.111S, S34.112S, S34.113S, S34.114S, S34.115S, S34.119S, S34.121S, S34.122S, S34.123S, S34.124S, S34.125S, S34.129S, S34.131S, S34.132S, S34.139S, S34.21XS, S34.22XS, S34.3XXS, S34.4XXS, S34.5XXS, S34.6XXS, S34.8XXS, S34.9XXS, S44.00XS, S44.01XS, S44.02XS, S44.10XS, S44.12XS, S44.20XS, S44.21XS, S44.22XS, S44.30XS, S44.31XS, S44.32XS, S44.40XS, S44.41XS, S44.42XS, S44.50XS, S44.51XS, S44.52XS, S44.8X1S, S44.8X2S, S44.8X9S, S44.90XS, S44.91XS, S44.92XS, S54.00XS, S54.01XS, S54.02XS, S54.10XS, S54.11XS, S54.12XS, S54.20XS, S54.21XS, S54.22XS, S54.30XS, S54.31XS, S54.32XS, S54.8X1S, S54.8X2S, S54.8X9S, S54.90XS, S54.91XS, S54.92XS, S64.00XS, S64.01XS, S64.02XS, S64.21XS, S64.22XS, S64.30XS, S64.31XS, S64.32XS, S64.40XS, S64.490S, S64.491S, S64.492S, S64.493S, S64.494S, S64.495S, S64.496S, S64.497S, S64.498S, S64.8X1S, S64.8X2S, S64.8X9S, S64.90XS, S64.91XS, S64.92XS, S74.00XS, S74.01XS, S74.02XS, S74.10XS, S74.11XS, S74.12XS, S74.20XS, S74.21XS, S74.22XS, S74.8X1S, S74.8X2, S74.8X9S, S74.90XS, S74.91XS, S74.92XS, S84.00XS, S84.01XS, S84.02XS, S84.10XS, S84.11XS, S84.12XS, S84.20XS, S84.21XS, S84.22XS, S84.801S, S84.802S, S84.809S, S84.90XS, S84.91XS, S84.92XS, S94.00XS, S94.01XS, S94.02XS, S94.10XS, S94.11XS, S94.12XS, S94.20XS, S94.21XS, S94.22XS, S94.30XS, S94.31XS, S94.32XS, S94.8X1S, S94.8X2S, S94.8X9S, S94.90XS, S94.91XS, S94.92XS
Bipolar Disorder
F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Major Depressive Disorder
F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39
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F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89
Alcohol Related
F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9
Substance Related
F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D, T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D,

T40.4X2A, T40.4X2D, T40.4X3A, T40.4X3D, T40.4X4A, T40.4X4D, T40.601A, T40.601D, T40.602A, T40.602D, T40.603A, T40.603D, T40.604A, T40.604D, T40.691A, T40.691D, T40.692A, T40.692D, T40.693A, T40.693D, T40.694A, T40.694D
Kidney Disease
N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0

I. Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

K. Appendix K – Whole Person Care Pilot Interaction Guidance

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

11. Consider Approval of Modifications to CalOptima Long Term Services and Supports Policies and Procedures related to Annual Policy Review

Contacts

Emily Fonda, MD, MMM, CHCQM, Deputy Chief Medical Officer (714) 246-8400
Tracy Hitzeman, RN, Executive Director Clinical Operations (714) 246-8400

Recommended Action(s)

Approve modifications to existing CalOptima Policies and Procedures for Long Term Services and Supports to be in compliance with Regulatory requirements as follows:

1. GG.1810: Bed Hold, Long Term Care
2. GG.1822 Process for Transitioning CalOptima Members Between Levels of Care

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. Below is additional information regarding the proposed policy modifications:

1. ***GG.1810: Bed Hold, Long Term Care***
   Minor revisions to improve clarity and readability.
2. ***GG.1822 Process for Transitioning CalOptima Members Between Levels of Care***
   Language added to the policy describing the process for member transitions from a long-term care (LTC) facility to a community setting, the facility's responsibility to notify CalOptima or the Health Network of a facility-initiated modification of a Member's level of care and coordinate in the planning for adjunctive long-term support services as appropriate.

Fiscal Impact

The recommended actions to revise CalOptima Policies GG.1810 and GG.1822 are operational in nature. Staff does not anticipate any additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2019-20 Operating Budget, approved by the Board on June 6, 2019.

Rationale for Recommendation

Approval is recommended to ensure that CalOptima is compliant with all federal, state, and local laws, and regulations.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Policy GG.1810: Bed Hold, Long Term Care (redlined and clean)
2. CalOptima Policy GG.1822 Process for Transitioning CalOptima Members Between Levels of Care (redlined and clean)

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

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Policy ~~#:~~:	GG.1810
Title:	**Bed Hold, Long-Term Care**
Department:	Medical Affairs
Section:	Long-Term Services and Supports
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/~~98~~1998
~~Last Review Date:~~	~~12/01/17~~
~~Last~~ Revised Date:	~~12/01/17~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

FOR 20191205BOD REVIEW

I. PURPOSE

This policy defines the terms by which ~~payment~~authorization review shall be made for **Bed Hold** days when a **Member** is transferred to a **General Acute Care Hospital** from a Long-Term Care (LTC) Facility, including a **Nursing Facility Level A (NF-A)**, **Nursing Facility Level B (NF-B)**, **Subacute Facility-Adult**, **Subacute Facility-Pediatric**, **Intermediate Care Facility (ICF)**, **Intermediate Care Facility-Developmentally Disabled (ICF/DD)**, **ICF/DD-Habilitative (ICF/DD-H)**, and **ICF/DD-Nursing (ICF/DD-N)**, in accordance with the **Member's** individual **Plan of Care**, and to ensure **Members** receive coordinated care across continuum of services.

II. POLICY

A. An LTC facility shall hold a bed vacant when requested by a **Member** or a **Member's Authorized Representative**, with a physician **Bed Hold** order, unless notified in writing by the attending physician that the **Member** requires more than seven (7) calendar days of **General Acute Care Hospital** services.

B. A **Bed Hold** for a **Member** transferred to a **General Acute Care Hospital** is limited to seven (7) calendar days per hospitalization.

1. The day of departure from the LTC facility shall be counted as one (1) day of **Bed Hold**.

2. The day of return to the LTC facility shall be counted as one (1) day of inpatient care.

C. The **Member's** attending physician must write a physician order for a discharge or transfer at the time a **Member** requires a discharge or transfer from an LTC facility to a **General Acute Care Hospital** and include an order for **Bed Hold**. The written order for **Bed Hold** on the electronic health record must match the supported document on paper health record. The date of **Bed Hold** must be the same as the admission date to a **General Acute Care Hospital**.

D. The LTC facility will hold the bed vacant during the **Bed Hold** period.

E. If an LTC facility is holding a bed and is notified in writing by the attending physician that the **Member** requires more than seven (7) days of general acute hospital care, the LTC facility shall no longer be required to hold the bed and shall not bill CalOptima for any remaining **Bed Hold** days.

F. There are no limits to the number of **Bed Hold** episodes. However, the **Member** shall remain at the facility at least twenty-four (24) hours prior to the start of the next **Bed Hold** period.

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G. CalOptima shall pay the LTC facility at the facility daily rate minus the cost of raw food for the **Bed Hold** days as established by the California Department of Health Care Services (DHCS).

H. CalOptima shall not pay for **Bed Hold** days when a **Member** is discharged from a facility that is receiving payment for **Bed Hold** within twenty-four (24) hours after the **Member's** return from an acute care hospital.

I. If a **Member** dies while hospitalized, the nursing facility shall terminate the **Bed Hold** and CalOptima shall not pay the facility for the **Bed Hold** for the day of death.

J. The LTC facility shall present the onsite CalOptima nurse or send the authorization request for **Bed Hold** reimbursement to CalOptima Long Term Services and Supports (LTSS) within twenty-one (21) calendar days after the end of the **Bed Hold**.

K. If CalOptima LTSS staff receives an authorization request after twenty-one (21) calendar days following the end of the **Bed Hold**, CalOptima shall consider the authorization late and shall not reimburse the nursing facility for the **Bed Hold**. The fifteen percent (15%) payment reduction does not apply to **Bed Hold** requests.

L. Pursuant to the requirements of this policy, the **Bed Hold** will be either approved or denied for the duration of the ~~timeframe. The fifteen percent (15%) payment reduction does not apply to Bed Hold requests~~time frame.

M. The **Bed Hold** ends on the day the **Member** returns to the nursing facility, reimbursement becomes the responsibility of another payer, or the **Member** does not return before the eighth (8th) day.

III. PROCEDURE

A. ~~The~~In order for the LTC facility to qualify for reimbursement for a Bed Hold, the **Member's** medical records maintained at the nursing facility must:

1. Indicate the name and the address of the intended destination;

2. Have a written Physician's transfer and **Bed Hold** order;

3. Have a start and an end date; and

4. Show the physician's order on electronic health record matches paper health record if the facility uses two types of health records.

B. Except as specified in Section III.D of this policy, CalOptima shall not require ~~a nursing~~an LTC facility to submit ~~an~~another LTC Authorization Request Form (ARF) for a **Member** with an active LTC ARF who returns to the facility on or before the seventh (7th) day of **Bed Hold**.

C. If a CalOptima **Member** on **Bed Hold** returns to the nursing facility after the seventh (7th) day of the **Bed Hold**, the **Member** is considered ~~as~~ a ~~re-admission~~readmission. The nursing facility shall ~~close out the active LTC – ARF and~~ submit the LTC ~~– disposition form~~Disposition Form to CalOptima's LTSS department within ~~twenty-four (24) hours~~one (1) business day of the **Bed Hold** discharge~~.~~ and complete a new authorization request. The CalOptima LTSS department shall close the active LTC authorization.

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D. The nursing facility shall follow admission procedures as set forth in CalOptima Policies GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B), GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N, and GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a **Subacute Facility-Adult/Pediatric**.

E. To receive authorization for the **Bed Hold** request, the LTC facility shall submit the following information with the LTC ARF within twenty-one (21) calendar days after the end of the **Bed Hold**:

1. A completed LTC ARF with an 'X' placed in the box marked '**Bed Hold**/LOA' with the dates of service for the **Bed Hold** request;

2. A copy of the physician's order to transfer the **Member** to the **General Acute Care Hospital** and **Bed Hold** order written at the time of transfer;

3. The **Member** or **Member's Authorized Representative** ~~consent or~~ request for **Bed Hold**; and

4. Nurse's notes or other clinical documentation as requested by LTSS staff to validate **Member's** status at the time of the transfer to **General Acute Care Hospital**.

IV. ATTACHMENT(S)

A. CalOptima Long--Term Care Authorization Request Form (LTC ARF)
B. CalOptima Discharge Disposition Form

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B).
C. CalOptima Policy GG.1802: ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from an ICF/DD, ICF/DD-H and ICF/DD-N
D. CalOptima Policy GG.1803: ~~ARF~~Authorization Process and Criteria for Admission to, Continued Stay in, ~~or~~and Discharge from a Subacute Facility-Adult/Pediatric
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medical Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
G. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 14-002: Requirements for Nursing Facility Services.
H. Department of Health Care Services (DHCS): Medi-Cal Long Term Care Provider Manual
I. Health and Safety Code, §1250(a)
J. Title 22, California Code of Regulations (CCR), §§ 51121, 51212, 51215, 51215.5, 51215.8, 51335(b)(3), 51535.0, 72520, 73504,76079, 76345, 76853

VI. REGULATORY AGENCY APPROVAL(S)

FOR 20161205BOD REVIEW

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A. 07/16/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

FOR 20191205BOD REVIEW

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	06/01/1998	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	07/15/1998	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	02/01/2007	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	07/01/2015	GG.1810Δ	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2015	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Correction	06/14/2016	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2016	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2017	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	TBD	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect

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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.
Bed Hold	For the purposes of this policy, means when a Member is transferred from a Skilled Nursing Facility (SNF~~)~~), including Subacute Facility, or Intermediate Care Facility (ICF) to a general acute care hospital and while hospitalized the ~~SNF or ICF~~facility holds the bed for up to seven (7) days until the Member returns to the ~~SNF or ICF~~same facility, as defined by Title 22, section 72520 and 73504.
General Acute Care Hospital	For the purposes of this policy, means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides twenty-four (24) hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services, per Health and Safety code, Section 1250 (a).
Intermediate Care Facility (ICF)	A health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.
Intermediate Care Facility/DD (Developmentally Disabled)	A facility that provides 24-hour personal care, habilitation, developmental, and support health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.
Intermediate Care Facility/DD-H (Habilitative)	A facility with a capacity of 4 to 15 beds that provide 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.
Intermediate Care Facility/DD-N (Nursing)	A facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.
Member	An enrollee-beneficiary of a CalOptima Program.
Nursing Facility Level A (NF-A)	Nursing Facility Level A (NF-A) is known as the Intermediate Care Level. NF-A level of care is characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.

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Term	Definition
Nursing Facility Level B (NF-B)	Nursing Facility Level B (NF-B) is known as the Skilled Nursing Facility level. NF-B level of care is characterized by and individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse, yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.
Plan of Care	An individual written plan of care completed, approved, and signed by a Physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).
Skilled Nursing Facility	Medi-Cal: Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program. OneCare Connect: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
Subacute Facility-Adult	A health facility that meets the standards set forth in Title 22, Section 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.
~~Subacute Facility-Pediatric~~	~~A health facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.~~

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Policy:	GG.1810
Title:	**Bed Hold, Long-Term Care**
Department:	Medical Affairs
Section:	Long-Term Services and Supports
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

FOR 20191205POD REVIEW

I. PURPOSE

This policy defines the terms by which authorization review shall be made for **Bed Hold** days when a **Member** is transferred to a **General Acute Care Hospital** from a Long-Term Care (LTC) Facility, including a **Nursing Facility Level A (NF-A)**, **Nursing Facility Level B (NF-B)**, **Subacute Facility-Adult**, **Subacute Facility-Pediatric**, **Intermediate Care Facility (ICF)**, **Intermediate Care Facility-Developmentally Disabled (ICF/DD)**, **ICF/DD-Habilitative (ICF/DD-H)**, and **ICF/DD-Nursing (ICF/DD-N)**, in accordance with the **Member's** individual **Plan of Care**, and to ensure **Members** receive coordinated care across continuum of services.

II. POLICY

A. An LTC facility shall hold a bed vacant when requested by a **Member** or a **Member's Authorized Representative**, with a physician **Bed Hold** order, unless notified in writing by the attending physician that the **Member** requires more than seven (7) calendar days of **General Acute Care Hospital** services.

B. A **Bed Hold** for a **Member** transferred to a **General Acute Care Hospital** is limited to seven (7) calendar days per hospitalization.

1. The day of departure from the LTC facility shall be counted as one (1) day of **Bed Hold**.

2. The day of return to the LTC facility shall be counted as one (1) day of inpatient care.

C. The **Member's** attending physician must write a physician order for a discharge or transfer at the time a **Member** requires a discharge or transfer from an LTC facility to a **General Acute Care Hospital** and include an order for **Bed Hold**. The written order for **Bed Hold** on the electronic health record must match the supported document on paper health record. The date of **Bed Hold** must be the same as the admission date to a **General Acute Care Hospital**.

D. The LTC facility will hold the bed vacant during the **Bed Hold** period.

E. If an LTC facility is holding a bed and is notified in writing by the attending physician that the **Member** requires more than seven (7) days of general acute hospital care, the LTC facility shall no longer be required to hold the bed and shall not bill CalOptima for any remaining **Bed Hold** days.

F. There are no limits to the number of **Bed Hold** episodes. However, the **Member** shall remain at the facility at least twenty-four (24) hours prior to the start of the next **Bed Hold** period.

G. CalOptima shall pay the LTC facility at the facility daily rate minus the cost of raw food for the **Bed Hold** days as established by the California Department of Health Care Services (DHCS).

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H. CalOptima shall not pay for **Bed Hold** days when a **Member** is discharged from a facility that is receiving payment for **Bed Hold** within twenty-four (24) hours after the **Member's** return from an acute care hospital.

I. If a **Member** dies while hospitalized, the nursing facility shall terminate the **Bed Hold** and CalOptima shall not pay the facility for the **Bed Hold** for the day of death.

J. The LTC facility shall present the onsite CalOptima nurse or send the authorization request for **Bed Hold** reimbursement to CalOptima Long Term Services and Supports (LTSS) within twenty-one (21) calendar days after the end of the **Bed Hold**.

K. If CalOptima LTSS staff receives an authorization request after twenty-one (21) calendar days following the end of the **Bed Hold**, CalOptima shall consider the authorization late and shall not reimburse the nursing facility for the **Bed Hold**. The fifteen percent (15%) payment reduction does not apply to **Bed Hold** requests.

L. Pursuant to the requirements of this policy, the **Bed Hold** will be either approved or denied for the duration of the time frame.

M. The **Bed Hold** ends on the day the **Member** returns to the nursing facility, reimbursement becomes the responsibility of another payer, or the **Member** does not return before the eighth (8th) day.

III. PROCEDURE

A. In order for the LTC facility to qualify for reimbursement for a Bed Hold, the **Member's** medical records maintained at the nursing facility must:

1. Indicate the name and the address of the intended destination;

2. Have a written Physician's transfer and **Bed Hold** order;

3. Have a start and an end date; and

4. Show the physician's order on electronic health record matches paper health record if the facility uses two types of health records.

B. Except as specified in Section III.D of this policy, CalOptima shall not require an LTC facility to submit another LTC Authorization Request Form (ARF) for a **Member** with an active LTC ARF who returns to the facility on or before the seventh (7th) day of **Bed Hold**.

C. If a CalOptima **Member** on **Bed Hold** returns to the nursing facility after the seventh (7th) day of the **Bed Hold**, the **Member** is considered a readmission. The nursing facility shall submit the LTC Disposition Form to CalOptima's LTSS department within one (1) business day of the **Bed Hold** discharge and complete a new authorization request. The CalOptima LTSS department shall close the active LTC authorization.

D. The nursing facility shall follow admission procedures as set forth in CalOptima Policies GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B), GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N, and GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a **Subacute Facility-Adult/Pediatric**.

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E. To receive authorization for the **Bed Hold** request, the LTC facility shall submit the following information with the LTC ARF within twenty-one (21) calendar days after the end of the **Bed Hold**:

1. A completed LTC ARF with an 'X' placed in the box marked '**Bed Hold**/LOA' with the dates of service for the **Bed Hold** request;

2. A copy of the physician's order to transfer the **Member** to the **General Acute Care Hospital** and **Bed Hold** order written at the time of transfer;

3. The **Member** or **Member's Authorized Representative** request for **Bed Hold**; and

4. Nurse's notes or other clinical documentation as requested by LTSS staff to validate **Member's** status at the time of the transfer to **General Acute Care Hospital**.

IV. ATTACHMENT(S)

A. CalOptima Long-Term Care Authorization Request Form (LTC ARF)
B. CalOptima Discharge Disposition Form

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B).
C. CalOptima Policy GG.1802: ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from an ICF/DD, ICF/DD-H and ICF/DD-N
D. CalOptima Policy GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medical Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
G. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 14-002: Requirements for Nursing Facility Services.
H. Department of Health Care Services (DHCS): Medi-Cal Long Term Care Provider Manual
I. Health and Safety Code, §1250(a)
J. Title 22, California Code of Regulations (CCR), §§ 51121, 51212, 51215, 51215.5, 51215.8, 51335(b)(3), 51535.0, 72520, 73504,76079, 76345, 76853

VI. REGULATORY AGENCY APPROVAL(S)

A. 07/16/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1998	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	07/15/1998	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	02/01/2007	GG.1810	Bed Hold, Long Term Care	Medi-Cal
Revised	07/01/2015	GG.1810Δ	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2015	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Correction	06/14/2016	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2016	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	12/01/2017	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect
Revised	TBD	GG.1810	Bed Hold, Long Term Care	Medi-Cal OneCare Connect

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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: Access by a Member's Authorized Representative.
Bed Hold	For the purposes of this policy, means when a Member is transferred from a Skilled Nursing Facility (SNF), including Subacute Facility, or Intermediate Care Facility (ICF) to a general acute care hospital and while hospitalized the facility holds the bed for up to seven (7) days until the Member returns to the same facility, as defined by Title 22, section 72520 and 73504.
General Acute Care Hospital	For the purposes of this policy, means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides twenty-four (24) hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services, per Health and Safety code, Section 1250 (a).
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Intermediate Care Facility/DD-H (Habilitative)	A facility with a capacity of 4 to 15 beds that provide 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.
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Member	An enrollee-beneficiary of a CalOptima Program.
Nursing Facility Level A (NF-A)	Nursing Facility Level A (NF-A) is known as the Intermediate Care Level. NF-A level of care is characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Nursing Facility Level B (NF-B)	Nursing Facility Level B (NF-B) is known as the Skilled Nursing Facility level. NF-B level of care is characterized by and individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse, yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.

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Term	Definition
Plan of Care	An individual written plan of care completed, approved, and signed by a Physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).
Skilled Nursing Facility	Medi-Cal: Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program. OneCare Connect: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
Subacute Facility-Adult	A health facility that meets the standards set forth in Title 22, Section 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.

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CalOptima
A Public Agency
Better. Together.

P.O. Box 11045
Orange, CA 92856
Phone No. 714-246-8444
Fax No. 714-246-8843

For CalOptima Use Only	*For CalOptima Use Only*
REFERENCE NO:	**Status:** ☐ Approved as Requested ☐ Denied ☐ Approved as Modified ☐ Deferred
	From: **To:**

Long-Term Care Authorization Request Form (Admissions)

☐ Initial ☐ Re-Authorization ☐ Retroactive Eligibility
☐ Bed Hold/Leave of Absence ☐ Retro-Authorization ☐ Treatment in Place (CCN only)

SECTION I

Bed Hold Start Date: _____ **Bed Hold End Date:** _____
Bed Hold Start Date: _____ **Bed Hold End Date:** _____

Date of Admission: **Dates of Service Requested:** **From:** **To:**

PROVIDER: Authorization does not guarantee payment. CalOptima ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F **D.O.B.** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

CIN#: _____ **Aid Code:** _____ **County Code:** _____

Facility Name:	**Physician Name:**
Facility Address: **City:** **ZIP:** **Phone:**	**Physician Address:** **City:** **ZIP:** **Phone:**
Fax Number:	**Fax Number:**
Medi-Cal Provider ID #/NPI:	**Physician Medi-Cal ID #:**
Former Facility: **Office Contact:**	**Physician Signature:**
Diagnosis:	**ICD - 10 Code:**

☐ **SNF** ☐ **ICF** ☐ **ICFDD** ☐ **ICFDDN** ☐ **ICFDDH** ☐ **SUBACUTE-VENT** ☐ **SUBACUTE-NON-VENT**

SECTION II Admitted From:
- ☐ Member's Home
- ☐ Household of Another
- ☐ Board & Care /Assisted Living
- ☐ Acute Hospital — Home, B&C Immediately prior to acute
- ☐ Acute Hospital — SNF/ICF Immediately prior to acute
- ☐ Another SNF/ICF

SECTION III

Date PASRR completed by NF: _____
Level II screening required: YES ☐ NO ☐
Date of referral: _____
Date Level II completed: _____
Pertinent Medications:

SECTION IV Patient's General Condition:
- ☐ Bedridden
- ☐ Ambulatory with Assistance
- ☐ Ambulatory
- ☐ Incontinent of B&B
- ☐ Confined to Wheelchair
- ☐ Maximum Assist with all ADLs

SECTION V

Community placement alternatives considered? YES ☐ NO ☐
If no, select all applicable boxes
- ☐ Community resources unavailable
- ☐ Due to, or change in medical, mental & physical functioning capability
- ☐ Caregiver unavailable
- ☐ Resident, conservator, or family choice
- ☐ Other

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: **Date:**

Long-Term Services & Supports (LTSS)
Long-Term Care (LTC)
Phone: 714-246-8444
Fax: 714-246-8843

Discharge Disposition Form

Nursing Facility Name		
Member Information	First Name:	Last Name:
Admission Date:	Discharge/Expired Date:	☐ Expired?
Client Identification Number (CIN):	Date of Birth:	
Address: (Discharge Destination)		Phone Number:
Name of Physician(s):	LTC Authorization Number:	
Discharge Diagnoses	ICD-10 Code:	Description:

IF EXPIRED, STOP HERE.

Discharge Plan

Most Recent Interdisciplinary Care Team (ICT) Meeting Date:		
Discharge Plan:		
Facility or Family Address Where Discharged:		
Selected Community PCP:	First Name:	Last Name:
Phone:	NPI/PID from Provider Directory:	
Address:		

Discharge Reason/ Disposition (check all that apply)

- ☐ Discharged to acute hospital/higher level of care
- ☐ Discharged to another SNF/ICF/SA
- ☐ Discharged to residence/home of another
- ☐ Discharged to board and care
- ☐ Discharged to motel
- ☐ Ineligible with CalOptima
- ☐ Left Against Medical Advice (AMA)
- ☐ No longer needs nursing facility services
- ☐ Poses risk to the health or safety of individuals in the nursing facility
- ☐ Other (specify):

Nursing Facility Offered Member Home- and Community-Based Services (HCBS) (check all that apply)

- ☐ 2-1-1 Orange County
- ☐ Aging & Disability Resource Connection
- ☐ AIDS Services Foundation
- ☐ Alzheimer's Association
- ☐ Assisted Living
- ☐ Board and Care Facility
- ☐ Case Management (CM) Program
- ☐ Community-Based Adult Services (CBAS)
- ☐ Community Care Transition (CCT)
- ☐ Dental
- ☐ Food Stamps
- ☐ Genetically Handicapped Person's Program (GHPP)
- ☐ Hemophilia Program
- ☐ Health Insurance Counseling & Advocacy Program (HICAP)
- ☐ Hospice
- ☐ Independent Living System
- ☐ In-Home Operations
- ☐ In-Home Supportive Services (IHSS)
- ☐ Legal Aid Society
- ☐ Meals on Wheels/Food Resource
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Orange County Housing
- ☐ Program of All-Inclusive Care for the Elderly (PACE)
- ☐ Regional Center of Orange County
- ☐ Shelter
- ☐ Transportation
- ☐ Waiver Program
- ☐ Other (specify):

Print Member/Representative Party Name:	Post Discharge Phone No.:
Facility Representative Signature:	Date:

Policy ~~#~~:	GG.1822
Title:	**Process for Transitioning CalOptima Members between Levels of Care**
Department:	Medical Affairs
Section:	Long ~~-~~-Term Services and Supports
CEO Approval:	Michael Schrader ~~-~~_____
Effective Date:	03/01/1999
~~Last Review Date:~~	~~11/01/17~~
~~Last~~ Revised Date:	~~11/01/17~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

FOR 20191205 POD REVIEW

I. PURPOSE

This policy outlines the process for transitioning **CalOptima Members** between **Levels of Care**~~,~~ **(LOC),** as well as into and out of **Long ~~-~~-Term Care**~~-~~ **(LTC).**

II. POLICY

A. Transfer from an acute care facility to a **Long ~~-~~-Term Care (LTC) Facility**

1. The discharge planning process from the acute setting shall include a review of the **Member's** ability to be discharged to a community setting with referrals to **Home and Community-Based Services (HCBS)** and other waiver programs prior to transferring to an **LTC Facility**.

2. The acute care facility shall be responsible for all discharge planning aspects of a **Member's** transfer to an **LTC Facility**.

3. **CalOptima**, or a **Health Network**, may assist in coordinating the discharge planning of a **Member** from an acute care **Facility** to an **LTC Facility**.

4. The acute care **Facility** shall collaborate with all appropriate **Interdisciplinary Care Team (ICT)** staff to facilitate the transfer of the **Member**.

5. The admitting **LTC Facility** shall coordinate the medical and ancillary services with **CalOptima**, the **Member's Health Network**, and other appropriate ~~agency, (e.g., California Children Services (CCS) and~~ agencies such as the Regional Center of Orange County (RCOC), as appropriate.

B. Transfer from an **LTC Facility** to an acute care facility

1. An **LTC Facility** shall be responsible for coordinating a planned, emergent, or urgent transfer of a **Member** to an acute care **Facility**.

2. An **LTC Facility** shall collaborate with all appropriate **ICT** staff to facilitate either a planned, emergent, or urgent transfer of a **Member** from ~~a~~an **LTC Facility** to an acute care facility.

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3. The **LTC Facility** shall notify the **CalOptima Long-Term Services and Supports (LTSS)** Department, or the **Member's Health Network**, of a **Member's** admission to an acute care facility through the twenty-one (21) day list processes requesting a bed hold.

4. **CalOptima**, or the **Member's Health Network**, shall be responsible for a **Member's** transportation from an acute care **Facility** to an **LTC Facility**, in accordance with **CalOptima** Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

5. Nursing facility may request a bed hold while a **Member** is in the acute setting. If a **Member** does not return before the bed hold expires, the **Member** will be discharged from **LTC Facility** in accordance with CalOptima Policy GG.1810: Bed Hold, Long-Term Care.

C. Transition from a **Health Network** to **CalOptima**'s **Long Term Care** Services upon termination of a **Member's Skilled Nursing Facility (SNF) Covered Services**

1. A **Health Network** shall notify the **SNF** and the **CalOptima LTSS** Department upon issuing the **Notice of Medicare Non-Coverage (NOMNC)**.

2. A **Health Network** shall submit a copy of the **NOMNC**, by facsimile, to the **CalOptima** LTSS Department upon issuing the notice, in accordance with **CalOptima** Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage. The **CalOptima LTSS** Department shall review the document during the **LTC** authorization review process.

~~3. A Health Network shall notify the CalOptima LTSS Department if a Member no longer meets Medical Necessity, or exhausts their Medicare SNF Covered Services, and the Member shall remain in the Facility under the CalOptima LTSS Medi-Cal benefit.~~

~~4.~~3. The **Facility** shall submit an **LTC** Authorization Request Form (ARF) to **CalOptima**'s **LTSS** Department in accordance with **CalOptima** policy.

D. Transition of care from skilled short stay to **LTC** custodial care (**CalOptima** Medi-Cal Only **Members Assigned to Health Networks** or Kaiser) shall include:

1. MD order; and

2. **LTC** ARF submitted to **CalOptima**'s **LTSS** Department, in accordance with **CalOptima** policy.

a) A denial letter from skilled short stay to **LTC** is not required.

E. An **LTC** facility may modify a **CalOptima Member's** level of care or coordinate a Member's discharge from the LTC facility, with appropriate physician signature approval, if the following specified circumstances are present:

1. The **LTC** facility is no longer capable of meeting the **member's** health care needs;

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2. The **member's** health has improved sufficiently, so that the **member** no longer needs nursing facility services; or

3. The **member** poses a risk to the health or safety of individuals in the facility.

F. When one (1) of the circumstances in Section II.E, above, presents itself, the **LTC facility** shall arrange and coordinate with **CalOptima** or a **Health Network** to discharge the **CalOptima Member** to the appropriate setting, including to the community with referrals for **Home and Community-Based Services (HCBS)**, as appropriate.

III. PROCEDURE

A. Transfer from an acute care Facility to an **LTC** Facility

1. Upon determination by the acute care Facility attending physician and the **ICT** that a Member meets the criteria for transfer to an **LTC** Facility, the attending physician shall write an order for transfer to an **LTC** Facility of the appropriate **Level of Care**.

2. The hospital discharge planner shall work with the family, **CalOptima**, the Member's Health Network, or RCOC, as appropriate, to find placement in a **CalOptima**-contracted **LTC** Facility.

3. The acute care facility shall collaborate with all appropriate **ICT** staff to facilitate the transfer including, but not limited to, a **CalOptima**, a Health Network representative, a **Primary Care Practitioner (PCP)**, the attending physician, hospital discharge planner, ancillary service providers, and outside agencies (e.g., ~~CCS,~~ RCOC, Orange County Behavioral Health Services (OCBHS).

4. Upon identification of an accepting **LTC** Facility, the hospital discharge planner shall coordinate the transfer, including transportation and Ancillary Services, with the physician, family, Facility, **CalOptima**, the Member's Health Network, ~~CalOptima Community Network (CCN), CCS,~~ RCOC, and OCBHS, as appropriate.

5. Upon a Member's admission to an **LTC** Facility, the **LTC** Facility shall notify the **CalOptima LTSS** Department of the admission within twenty-one (21) calendar days after admission, or twenty-one (21) calendar days after **CalOptima** becomes financially responsible for the Member's admission, whichever is later.

B. Planned transfer from an **LTC** Facility to an acute care facility

1. Upon determination by the **LTC** Facility that a Member requires a planned admission to an acute care Facility, the Member's attending physician shall obtain authorization for the acute care admission from **CalOptima**, the Member's Health Network, or CCS, as appropriate.

2. The attending physician shall initiate the discharge planning orders and inter-facility transfer orders.

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3. The **LTC Facility** shall coordinate the transfer, including transportation and ancillary services, with the physician, family, **Facility**, **CalOptima**, the **Member's Health Network**, ~~CCS,~~ RCOC, and OCBHS, as appropriate.

4. The **LTC Facility** shall verify with the **Member**, the **Member's Authorized Representative**, or RCOC, as appropriate, if a bed hold is requested. If a bed hold is requested, the **LTC Facility** shall hold the bed for the **Member**, in accordance with **CalOptima** Policy GG.1810: Bed Hold, Long-~~-~~Term Care.

5. Upon admission to the acute care facility, the acute care facility shall notify **CalOptima**, the **Member's Health Network**~~, including CCN, or CCS~~ of the admission, as appropriate.

C. Urgent or emergent transfer from an **LTC Facility** to an acute care **Facility**

1. Upon ~~a~~an **LTC Facility** identification of a **Member** requiring emergent acute care admission, the **LTC Facility** shall call for 911 transport of the **Member**.

2. The **LTC Facility** shall notify the attending physician of the urgent transfer and the attending physician shall order the 911 transfer.

3. The **LTC Facility** shall verify with the **Member**, the **Member's Authorized Representative**, or RCOC, as appropriate, if a bed hold is requested. If a bed hold is requested, the **LTC Facility** shall hold the bed for the **Member**, in accordance with **CalOptima** Policy GG.1810: Bed Hold, Long-~~-~~Term Care.

D. Transition from a **Health Network** skilled nursing short-~~-~~term stay to **Long-~~-~~Term Care** (**LTC**)

1. If a **Member** no longer meets **Medical Necessity** criteria, or exhausts his or her Medicare **SNF Covered Services**, the **Member** will remain in the **Facility** under the **CalOptima LTC** Medi-Cal benefit. The **Nursing Facility** shall notify **CalOptima** ~~LTC~~**LTSS** Department ~~the~~ by using the **LTC** Authorization Request Form (ARF), including **Notice of Medicare Non-Coverage (**~~NOCMNC~~**NOMNC)** letter if applicable and MD order from the **Member's Health Network**.

2. **CalOptima** shall ~~grant~~review the authorization request and make a determination in accordance with **CalOptima** Policy GG.1800: Authorization Process and Criteria for Admission, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B).

E. Transition from an **LTC** facility to a community setting

1. The **LTC** facility shall notify **CalOptima** or a **Health Network** of the **Member's** capacity and preference for discharging to a community setting as soon as the information is available to provide sufficient time to safely plan and coordinate the transition.

2. **CalOptima** or a **health network** shall work with the **LTC facility** to ensure that all **Medically Necessary** services are provided in a timely manner upon discharge, and the **Member's** transition to the most appropriate level of community-based care meets the **Member's** medical

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and social needs. The **Member's** medical needs, supports, and services throughout the transition and post-discharge period shall be coordinated and may include, but is not limited to:

a. Documentation of pre-admission, or baseline status;

b. Coordination with appropriate waiver and other specialized programs such as the California Community Transitions Project (CCT) or the Home and Community Based Alternative Waiver (HCBA) to support the **Member** during the transition and ensure adequacy of resources post-discharge;

c. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community based **LTSS** programs;

d. Initial coordination of care, as appropriate with the **member's** caregiver, other agencies and healthcare personnel; and

e. Provision of information for making follow-up appointments.

3. The **LTSS** Department Staff shall make a referral to the Case Management Department or a **Health Network**, as appropriate, when the member is discharged from the **LTC facility**.

IV. ATTACHMENTS

A. CalOptima Long~~-~~-Term Care (LTC) Authorization Request Form (ARF)

V. REFERENCES

A. Californian Children Services and CalOptima Memorandum of Understanding
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy EE.1135: Long~~-~~-Term Care ~~Facility~~facility Contracting
D. CalOptima Policy GG.1505: Transportation, Emergency, Non-emergency and Non-Medical
E. CalOptima Policy GG.1800: Authorization Process and Criteria for Admission, Continued Stay in, and Discharge from a Nursing ~~Facility~~facility Level A (NF-A) and Nursing ~~Facility~~facility Level B (NF-B)
F. CalOptima Policy GG.1810: Bed Hold, Long~~-~~-Term Care
G. CalOptima Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage
~~G.~~H. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~H.~~I. CalOptima Utilization Management Plan
~~I.~~J. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
~~J.~~K. Long~~-~~-Term Care ~~Facility~~facility Agreement
~~K.~~L. Regional Center of Orange County and CalOptima Memorandum of Understanding
~~L.~~M. Title 22, California Code of Regulations (CCR), §§ 51121, 51212, 51215, 51215.5, 51215.8, 76079, 76345 and 76853

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N. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 14-002: Requirements for Nursing facility Services.
O. Department of Health Care Services (DHCS) 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.

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

A. 05/26/16: Department of Health Care Services

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

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	03/1999	GG.1822	Process for Transferring CalOptima Members between Acute Care Facilities to Long-Term Care Facilities	Medi-Cal
Effective	08/01/2005	MA.6018	Member Transfer from Skilled Nursing Long-Term Care	OneCare
Revised	04/01/2007	GG.1822	Process for Transferring CalOptima Members between Acute Care Facilities to Long-Term Care Facilities	Medi-Cal
Revised	02/01/2016	GG.1822	Process for Transferring CalOptima Member between Acute Care Facilities to Long-Term Care	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1822	Process for Transferring CalOptima Members between Care Facilities	Medi-Cal OneCare Connect
Retired	10/11/2016	MA.6018	Member Transfer from Skilled Nursing Long-Term Care	OneCare
Revised	11/01/2017	GG.1822	Process for Transferring CalOptima Members between Levels of Care	Medi-Cal OneCare Connect
Revised	TBD	GG. 1822	Process for Transferring CalOptima Members between Levels of Care	Medi-Cal OneCare Connect

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IX. GLOSSARY

Term	Definition
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
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 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 (CCR), Sections 41515.2 through 41518.9.~~
CalOptima	For the purposes of this policy, CalOptima shall include CalOptima Community Network (CNN).
CalOptima Community Network (CCN)	CalOptima's own health network created to improve care management for their Members and physicians.
Community-Based Adult Services (CBAS)	An outpatient program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services, to eligible Members who meet applicable eligibility criteria.
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 Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).

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Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Home and Community-Based Services (HCBS)	Home and Community-Based Services (HCBS) benefit is defined by the services listed in Title 42, Code of Federal Regulations, Section 440.182(c).
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individualized Plan of Care.
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.
Long Term Care (LTC)	For purposes of this policy, care provided for Members in a Skilled Nursing ~~Facility~~facility and subacute care services.
Long-~~-~~Term Care ~~Facility~~facility	For the purposes of this policy, includes a Nursing ~~Facility~~facility Level A (NF-A) [Intermediate Care ~~Facility~~facility (ICF) or Subacute ~~Facility~~facility] and Nursing ~~Facility~~facility Level B (NF-B) [Skilled Nursing ~~Facility~~facility (SNF)].
Long-~~-~~Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: ~~1. In-Home Supportive Services (IHSS);~~ ~~2.~~1. Community-Based Adult Services (CBAS); ~~3.~~2. Multipurpose Senior Services Program (MSSP) services; and ~~4.~~3. Skilled nursing facility services and subacute care services.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee-beneficiary of a CalOptima program.
Notice of Medicare Non-Coverage (NOMNC)	A document that informs Members when their Medicare covered service(s) is ending and how to request an expedited determination from their Quality Improvement Organization (QIO).
Plan of Care	An individual written plan of care completed, approved, and signed by a physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).

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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, "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).
Skilled Nursing ~~Facility~~facility (SNF)	Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program.

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Policy:	GG.1822
Title:	**Process for Transitioning CalOptima Members between Levels of Care**
Department:	Medical Affairs
Section:	Long-Term Services and Supports
CEO Approval:	Michael Schrader _____
Effective Date:	03/01/1999
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

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I. PURPOSE

This policy outlines the process for transitioning **CalOptima Members** between **Levels of Care (LOC)**, as well as into and out of **Long-Term Care (LTC)**.

II. POLICY

A. Transfer from an acute care facility to a **Long-Term Care (LTC) Facility**

1. The discharge planning process from the acute setting shall include a review of the **Member's** ability to be discharged to a community setting with referrals to **Home and Community-Based Services (HCBS)** and other waiver programs prior to transferring to an **LTC Facility**.

2. The acute care facility shall be responsible for all discharge planning aspects of a **Member's** transfer to an **LTC Facility**.

3. **CalOptima**, or a **Health Network**, may assist in coordinating the discharge planning of a **Member** from an acute care **Facility** to an **LTC Facility**.

4. The acute care **Facility** shall collaborate with all appropriate **Interdisciplinary Care Team (ICT)** staff to facilitate the transfer of the **Member**.

5. The admitting **LTC Facility** shall coordinate the medical and ancillary services with **CalOptima**, the **Member's Health Network**, and other appropriate agencies such as the Regional Center of Orange County (RCOC), as appropriate.

B. Transfer from an **LTC Facility** to an acute care facility

1. An **LTC Facility** shall be responsible for coordinating a planned, emergent, or urgent transfer of a **Member** to an acute care **Facility**.

2. An **LTC Facility** shall collaborate with all appropriate **ICT** staff to facilitate either a planned, emergent, or urgent transfer of a **Member** from an **LTC Facility** to an acute care facility.

3. The **LTC Facility** shall notify the **CalOptima Long-Term Services and Supports (LTSS)** Department, or the **Member's Health Network**, of a **Member's** admission to an acute care facility through the twenty-one (21) day list processes requesting a bed hold.

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4. **CalOptima**, or the **Member's Health Network**, shall be responsible for a **Member's** transportation from an acute care **Facility** to an **LTC Facility**, in accordance with **CalOptima** Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

5. Nursing facility may request a bed hold while a **Member** is in the acute setting. If a **Member** does not return before the bed hold expires, the **Member** will be discharged from **LTC Facility** in accordance with CalOptima Policy GG.1810: Bed Hold, Long-Term Care.

C. Transition from a **Health Network** to **CalOptima**'s **Long Term Care** Services upon termination of a **Member's Skilled Nursing Facility (SNF) Covered Services**

1. A **Health Network** shall notify the **SNF** and the **CalOptima LTSS** Department upon issuing the **Notice of Medicare Non-Coverage (NOMNC)**.

2. A **Health Network** shall submit a copy of the **NOMNC**, by facsimile, to the **CalOptima** LTSS Department upon issuing the notice, in accordance with **CalOptima** Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage. The **CalOptima LTSS** Department shall review the document during the **LTC** authorization review process.

3. The **Facility** shall submit an **LTC** Authorization Request Form (ARF) to **CalOptima**'s **LTSS** Department in accordance with **CalOptima** policy.

D. Transition of care from skilled short stay to **LTC** custodial care (**CalOptima** Medi-Cal Only **Members Assigned to Health Networks** or Kaiser) shall include:

1. MD order; and

2. **LTC** ARF submitted to **CalOptima**'s **LTSS** Department, in accordance with **CalOptima** policy.

    a) A denial letter from skilled short stay to **LTC** is not required.

E. An **LTC** facility may modify a **CalOptima Member's** level of care or coordinate a Member's discharge from the LTC facility, with appropriate physician signature approval, if the following specified circumstances are present:

1. The **LTC** facility is no longer capable of meeting the **member's** health care needs;

2. The **member's** health has improved sufficiently, so that the **member** no longer needs nursing facility services; or

3. The **member** poses a risk to the health or safety of individuals in the facility.

F. When one (1) of the circumstances in Section II.E, above, presents itself, the **LTC facility** shall arrange and coordinate with **CalOptima** or a **Health Network** to discharge the **CalOptima Member** to the appropriate setting, including to the community with referrals for **Home and Community-Based Services (HCBS)**, as appropriate.

III. PROCEDURE

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A. Transfer from an acute care Facility to an **LTC** Facility

1. Upon determination by the acute care Facility attending physician and the **ICT** that a Member meets the criteria for transfer to an **LTC** Facility, the attending physician shall write an order for transfer to an **LTC** Facility of the appropriate **Level of Care**.

2. The hospital discharge planner shall work with the family, **CalOptima**, the Member's Health Network, or RCOC, as appropriate, to find placement in a **CalOptima**-contracted **LTC** Facility.

3. The acute care facility shall collaborate with all appropriate **ICT** staff to facilitate the transfer including, but not limited to, a **CalOptima**, a Health Network representative, a **Primary Care Practitioner (PCP)**, the attending physician, hospital discharge planner, ancillary service providers, and outside agencies (e.g., RCOC, Orange County Behavioral Health Services (OCBHS).

4. Upon identification of an accepting **LTC** Facility, the hospital discharge planner shall coordinate the transfer, including transportation and Ancillary Services, with the physician, family, Facility, **CalOptima**, the Member's Health Network, RCOC, and OCBHS, as appropriate.

5. Upon a Member's admission to an **LTC** Facility, the **LTC** Facility shall notify the **CalOptima LTSS** Department of the admission within twenty-one (21) calendar days after admission, or twenty-one (21) calendar days after **CalOptima** becomes financially responsible for the Member's admission, whichever is later.

B. Planned transfer from an **LTC** Facility to an acute care facility

1. Upon determination by the **LTC** Facility that a Member requires a planned admission to an acute care Facility, the Member's attending physician shall obtain authorization for the acute care admission from **CalOptima**, the Member's Health Network, or CCS, as appropriate.

2. The attending physician shall initiate the discharge planning orders and inter-facility transfer orders.

3. The **LTC Facility** shall coordinate the transfer, including transportation and ancillary services, with the physician, family, **Facility**, **CalOptima**, the **Member's Health Network**, RCOC, and OCBHS, as appropriate.

4. The **LTC Facility** shall verify with the **Member**, the **Member's Authorized Representative**, or RCOC, as appropriate, if a bed hold is requested. If a bed hold is requested, the **LTC Facility** shall hold the bed for the **Member**, in accordance with **CalOptima** Policy GG.1810: Bed Hold, Long-Term Care.

5. Upon admission to the acute care facility, the acute care facility shall notify **CalOptima**, the **Member's Health Network** of the admission, as appropriate.

C. Urgent or emergent transfer from an **LTC Facility** to an acute care **Facility**

1. Upon an **LTC Facility** identification of a **Member** requiring emergent acute care admission, the **LTC Facility** shall call for 911 transport of the **Member**.

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2. The **LTC Facility** shall notify the attending physician of the urgent transfer and the attending physician shall order the 911 transfer.

3. The **LTC Facility** shall verify with the **Member**, the **Member's Authorized Representative**, or RCOC, as appropriate, if a bed hold is requested. If a bed hold is requested, the **LTC Facility** shall hold the bed for the **Member**, in accordance with **CalOptima** Policy GG.1810: Bed Hold, Long-Term Care.

D. Transition from a **Health Network** skilled nursing short-term stay to **Long-Term Care** (**LTC**)

1. If a **Member** no longer meets **Medical Necessity** criteria, or exhausts his or her Medicare **SNF Covered Services**, the **Member** will remain in the **Facility** under the **CalOptima LTC** Medi-Cal benefit. The **Nursing Facility** shall notify **CalOptima LTSS** Department by using the **LTC** Authorization Request Form (ARF), including **Notice of Medicare Non-Coverage (NOMNC)** letter if applicable and MD order from the **Member's Health Network**.

2. **CalOptima** shall review the authorization request and make a determination in accordance with **CalOptima** Policy GG.1800: Authorization Process and Criteria for Admission, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B).

E. Transition from an **LTC** facility to a community setting

1. The **LTC** facility shall notify **CalOptima** or a **Health Network** of the **Member's** capacity and preference for discharging to a community setting as soon as the information is available to provide sufficient time to safely plan and coordinate the transition.

2. **CalOptima** or a **health network** shall work with the **LTC facility** to ensure that all **Medically Necessary** services are provided in a timely manner upon discharge, and the **Member's** transition to the most appropriate level of community-based care meets the **Member's** medical and social needs. The **Member's** medical needs, supports, and services throughout the transition and post-discharge period shall be coordinated and may include, but is not limited to:

   a. Documentation of pre-admission, or baseline status;

   b. Coordination with appropriate waiver and other specialized programs such as the California Community Transitions Project (CCT) or the Home and Community Based Alternative Waiver (HCBA) to support the **Member** during the transition and ensure adequacy of resources post-discharge;

   c. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community based **LTSS** programs;

   d. Initial coordination of care, as appropriate with the **member's** caregiver, other agencies and healthcare personnel; and

   e. Provision of information for making follow-up appointments.

3. The **LTSS** Department Staff shall make a referral to the Case Management Department or a **Health Network**, as appropriate, when the member is discharged from the **LTC facility**.

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IV. ATTACHMENTS

A. CalOptima Long-Term Care (LTC) Authorization Request Form (ARF)

V. REFERENCES

A. Californian Children Services and CalOptima Memorandum of Understanding
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy EE.1135: Long-Term Care facility Contracting
D. CalOptima Policy GG.1505: Transportation, Emergency, Non-emergency and Non-Medical
E. CalOptima Policy GG.1800: Authorization Process and Criteria for Admission, Continued Stay in, and Discharge from a Nursing facility Level A (NF-A) and Nursing facility Level B (NF-B)
F. CalOptima Policy GG.1810: Bed Hold, Long-Term Care
G. CalOptima Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage
H. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. CalOptima Utilization Management Plan
J. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
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L. Regional Center of Orange County and CalOptima Memorandum of Understanding
M. Title 22, California Code of Regulations (CCR), §§ 51121, 51212, 51215, 51215.5, 51215.8, 76079, 76345 and 76853
N. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 14-002: Requirements for Nursing facility Services.
O. Department of Health Care Services (DHCS) 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.

VI. REGULATORY AGENCY APPROVAL(S)

A. 05/26/16: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/1999	GG.1822	Process for Transferring CalOptima Members between Acute Care Facilities to Long-Term Care Facilities	Medi-Cal
Effective	08/01/2005	MA.6018	Member Transfer from Skilled Nursing Long-Term Care	OneCare

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2007	GG.1822	Process for Transferring CalOptima Members between Acute Care Facilities to Long-Term Care Facilities	Medi-Cal
Revised	02/01/2016	GG.1822	Process for Transferring CalOptima Member between Acute Care Facilities to Long-Term Care	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1822	Process for Transferring CalOptima Members between Care Facilities	Medi-Cal OneCare Connect
Retired	10/11/2016	MA.6018	Member Transfer from Skilled Nursing Long-Term Care	OneCare
Revised	11/01/2017	GG.1822	Process for Transferring CalOptima Members between Levels of Care	Medi-Cal OneCare Connect
Revised	TBD	GG. 1822	Process for Transferring CalOptima Members between Levels of Care	Medi-Cal OneCare Connect

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IX. GLOSSARY

Term	Definition
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
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: Access by a Member's Authorized Representative.
CalOptima	For the purposes of this policy, CalOptima shall include CalOptima Community Network (CNN).
CalOptima Community Network (CCN)	CalOptima's own health network created to improve care management for their Members and physicians.
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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 Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
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.
Home and Community-Based Services (HCBS)	Home and Community-Based Services (HCBS) benefit is defined by the services listed in Title 42, Code of Federal Regulations, Section 440.182(c).
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individualized Plan of Care.
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.

FOR 2019 12/05 BOD REVIEW

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Term	Definition
Long Term Care (LTC)	For purposes of this policy, care provided for Members in a Skilled Nursing facility and subacute care services.
Long-Term Care facility	For the purposes of this policy, includes a Nursing facility Level A (NF-A) [Intermediate Care facility (ICF) or Subacute facility] and Nursing facility Level B (NF-B) [Skilled Nursing facility (SNF)].
Long-Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; and 3. Skilled nursing facility services and subacute care services.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee-beneficiary of a CalOptima program.
Notice of Medicare Non-Coverage (NOMNC)	A document that informs Members when their Medicare covered service(s) is ending and how to request an expedited determination from their Quality Improvement Organization (QIO).
Plan of Care	An individual written plan of care completed, approved, and signed by a physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).
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).
Skilled Nursing facility (SNF)	Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program.

FOR 20160205 BOD REVIEW

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CalOptima
A Public Agency
Better. Together.

P.O. Box 11045
Orange, CA 92856
Phone No. 714-246-8444
Fax No. 714-246-8843

For CalOptima Use Only	*For CalOptima Use Only*
REFERENCE NO:	**Status:** ☐ Approved as Requested ☐ Denied ☐ Approved as Modified ☐ Deferred
	From: **To:**

Long-Term Care Authorization Request Form (Admissions)

☐ Initial ☐ Re-Authorization ☐ Retroactive Eligibility
☐ Bed Hold/Leave of Absence ☐ Retro-Authorization ☐ Treatment in Place (CCN only)

SECTION I

Bed Hold Start Date: _____ Bed Hold End Date: _____
Bed Hold Start Date: _____ Bed Hold End Date: _____

Date of Admission: **Dates of Service Requested:** **From:** **To:**

PROVIDER: Authorization does not guarantee payment. CalOptima ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F **D.O.B.** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

CIN#: _____ **Aid Code:** _____ **County Code:** _____

Facility Name:	**Physician Name:**
Facility Address: **City:** **ZIP:** **Phone:**	**Physician Address:** **City:** **ZIP:** **Phone:**
Fax Number:	**Fax Number:**
Medi-Cal Provider ID #/NPI:	**Physician Medi-Cal ID #:**
Former Facility: **Office Contact:**	**Physician Signature:**
Diagnosis:	**ICD - 10 Code:**

☐ **SNF** ☐ **ICF** ☐ **ICFDD** ☐ **ICFDDN** ☐ **ICFDDH** ☐ **SUBACUTE-VENT** ☐ **SUBACUTE-NON-VENT**

SECTION II Admitted From:

- ☐ Member's Home
- ☐ Household of Another
- ☐ Board & Care /Assisted Living
- ☐ Acute Hospital — Home, B&C Immediately prior to acute
- ☐ Acute Hospital — SNF/ICF Immediately prior to acute
- ☐ Another SNF/ICF

SECTION III

Date PASRR completed by NF: _____
Level II screening required: YES ☐ NO ☐
Date of referral: _____
Date Level II completed: _____
Pertinent Medications:

SECTION IV Patient's General Condition:

- ☐ Bedridden
- ☐ Ambulatory with Assistance
- ☐ Ambulatory
- ☐ Incontinent of B&B
- ☐ Confined to Wheelchair
- ☐ Maximum Assist with all ADLs

SECTION V

Community placement alternatives considered? YES ☐ NO ☐
If no, select all applicable boxes

- ☐ Community resources unavailable
- ☐ Due to, or change in medical, mental & physical functioning capability
- ☐ Caregiver unavailable
- ☐ Resident, conservator, or family choice
- ☐ Other

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: **Date:**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Consider Adoption of Resolution Approving Revised CalOptima 2020 Compliance Plan and Authorizing the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures

Rev. 12/5/19

Contact

Silver Ho, Compliance Officer, (714) 246-8400

Recommended Actions

1. Adopt Resolution No. 19-1205-01, Approving Revised CalOptima 2020 Compliance Plan; and
2. Authorize the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures.

Background

CalOptima is committed to conducting its operations in compliance with ethical standards and all applicable laws, regulations, and rules, including those pertaining to its Federal and State health care program requirements. As part of that commitment, on December 6, 2018, the CalOptima Board of Directors reviewed and approved the updated Compliance Plan, which includes the Code of Conduct, and the Fraud, Waste, and Abuse (FWA) Plan. The Compliance Plan comprehensively addresses the fundamental elements necessary for an effective Compliance Program, including those elements identified by the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) and the Centers for Medicare & Medicaid Services (CMS).

Discussion

CalOptima regularly reviews the Compliance Plan to ensure it is up-to-date and aligned with Federal and State health care program requirements and laws as well as CalOptima operations. CalOptima's Executive Director of Compliance (Compliance Officer) has reviewed the Compliance Plan and Office of Compliance Policies and Procedures to ensure consistency with applicable Federal and State health care program laws, regulations, and/or guidance.

Compliance Program Elements

Federal laws and regulations (including the federal U.S. Sentencing Guidelines, CMS Medicare Advantage regulations) and the OIG compliance guidance require that Compliance Programs be reasonably designed, implemented, and enforced, to ensure the Compliance Program is effective in preventing and detecting violations of standards or law. CalOptima's Compliance Program addresses each of the seven (7) fundamental elements of an effective Compliance Program, in addition to FWA detection, prevention, and remediation.

Written Standards

As part of the Compliance Program, CalOptima develops, maintains, and distributes to its Board Members, Employees, and First Tier, Downstream or Related Entities (FDRs) written standards in the form of the Compliance Plan, a Code of Conduct, and written Policies and Procedures, as further detailed in the Compliance Plan. The Compliance Plan incorporates all the elements of an effective

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Compliance Program as recommended by the OIG and required by CMS regulations. The Compliance Plan also incorporates a comprehensive FWA section, which establishes guidelines and procedures designed to detect, prevent, and remediate FWA in CalOptima Programs.

Oversight
The CalOptima Board of Directors (the "Board"), the governing body of CalOptima, is responsible for ensuring and overseeing the implementation, effectiveness, and continued operation of the Compliance Program. The Board delegates to the CEO, who then delegates to the Compliance Officer, a CalOptima Employee, the administration of the Compliance Program's development, maintenance, implementation, monitoring, and enforcement activities. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in the Compliance Plan. The Audit & Oversight Committee (AOC), a subcommittee of the Compliance Committee, is responsible for overseeing the internal business and delegated activities.

Training and Education
Utilizing web-based training courses, as well as distribution of guidelines and publications, the Compliance Program incorporates training and educational courses governing CalOptima's compliance standards and requirements, as well as specialized educational courses assigned to individuals based on their respective roles, or positions, within, or with, CalOptima's departments and its programs. CalOptima Board Members, Employees, and FDRs receive copies of CalOptima's Code of Conduct and are required to complete comprehensive training covering compliance obligations and applicable laws, FWA (where applicable), and Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements, upon appointment, hire, or commencement of a contract, as applicable, and annually thereafter.

Effective Lines of Communication and Reporting
CalOptima utilizes various methods to communicate general information, regulatory updates, and process changes from the Compliance Officer to CalOptima Board Members, Employees, FDRs, and members, including, but not limited to, presentations at meetings and updates in print and/or electronic form, including information on how to identify, report, and prevent compliance issues and FWA. CalOptima Board Members, Employees, FDRs, and/or Members receive information and reminders to report compliance concerns, questionable conduct or practices, and suspected, or actual, non-compliance issues, or FWA incidents, through one (1) of CalOptima's multiple reporting mechanisms. These reporting options, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). CalOptima maintains and supports a no retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

Enforcement and Disciplinary Standards
Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions for non-compliance with CalOptima's standards, requirements, or applicable laws as specified in the Compliance Program documents and related Policies and Procedures, including, but not limited to, CalOptima's policies on Performance and Behavior Standards, Corrective Action Plans, and/or Sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance, or unethical behavior, is determined, and appropriate disciplinary action is implemented to address improper conduct, activity, and/or behavior.

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Monitoring, Auditing, and Identification of Risks
CalOptima has implemented and continues to implement comprehensive monitoring and auditing activities related to its operations and those of its FDRs. The purpose of CalOptima's monitoring and auditing activities is to test and confirm compliance with all applicable regulations, contractual agreements, and Federal and State laws, as well as applicable Policies and Procedures established to protect against non-compliance and potential FWA in CalOptima Programs. The Compliance Plan and related Policies and Procedures, address the monitoring and auditing processes that are carried out by CalOptima.

Response and Remediation
Once a violation, or an offense, has been detected or reported, CalOptima initiates all necessary steps to investigate, identify, and respond appropriately to the violation, or offense, and to prevent similar violations and offenses from occurring. As described in the Compliance Plan, CalOptima will conduct a timely and documented investigation, and undertake appropriate corrective actions where appropriate, including, but not limited to, modifying its Compliance Program and its Policies and Procedures to prevent the same, or similar, violation or offense, from occurring in the future.

Summary of Changes
The Compliance Plan has been updated and revised as follows:
- Clearly defined Executive Staff and Management;
- Revised language to clarify CalOptima's responsibility to return overpayments;
- Removed details of the Office of Compliance filing system and aligned with CalOptima Policy HH.2022Δ: Record Retention and Access;
- Deleted affirmation statements for Compliance Training; and
- Added new terms to the Glossary.

Policies and Procedures
To align with the revised Compliance Plan, and consistent with applicable Federal and State health care program laws, regulations and/or guidance, the Compliance Officer, with the support of the Office of Compliance staff, updated related Policies and Procedures. The summary of changes is included in Attachment 3.

Fiscal Impact
There is no anticipated fiscal impact based on the adoption of the updates to the 2020 Compliance Plan and its related Policies and Procedures. To the extent that there is any fiscal impact due to increases in Compliance Program resources, such impact will be addressed in separate Board actions or in the CalOptima Fiscal Year 2020-21 Operating Budget.

Rationale for Recommendation
To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt CalOptima's updated 2020 Compliance Plan, and related Policies and Procedures. The updated 2020 Compliance Plan will supersede the prior updated Compliance Plan and

Code of Conduct approved on December 6, 2018. Staff also recommends that the Board approve and adopt revised, related Policies and Procedures to implement the updated 2020 Compliance Plan.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 19-1205-01, Resolution Approving CalOptima's Updated 2020 Compliance Plan and Authorize the Board of Directors to approve revised policies and procedures.
2. Draft 2020 Compliance Plan (redlined and clean versions).
3. Summary of Proposed Actions to CalOptima Office of Compliance Policies and Procedures.
4. Revised Office of Compliance Policies and Procedures (redlined and clean versions).

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

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RESOLUTION NUMBER 19-1205-01

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima

APPROVING CALOPTIMA'S UPDATED 2020 COMPLIANCE PLAN

WHEREAS, Section 4.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provides that the Board of Directors is the governing body of CalOptima, and except as otherwise provided by the Bylaws or by Ordinance, the powers of CalOptima shall be exercised, its property controlled and its business and affairs conducted by or under the direction of the Board; and

WHEREAS, the Board of Directors has responsibility for approving, implementing, and monitoring a Compliance Program governing CalOptima's operations consistent will all applicable laws, regulations, and guidelines; and

WHEREAS, the Board of Directors supports CalOptima's commitment to compliant, lawful, and ethical conduct, and values the importance of compliance and ethics in Caloptima's operations; and

WHEREAS, the Board of Directors last reviewed and approved the Compliance Program on December 6, 2018 including the Compliance Plan, Code of Conduct, and related policies and procedures; and

WHEREAS, the Board of Directors reviews the Compliance Program documents on a periodic basis to ensure the Compliance Program is consistent with and updated to reflect applicable laws, regulations, and guidelines and to demonstrate the Board of Director's commitment to an effective Compliance Program.

NOW THEREFORE, BE IT RESOLVED:

Section 1. The Board of Directors hereby approves the 2020 Compliance Plan, including the Fraud, Waste, and Abuse Plan, and the Code of Conduct.

Section 2. The Board of Directors hereby approves and adopts the revised Office of Compliance Policies and Procedures.

Section 3. The Chief Executive Officer or his/her designee is hereby authorized and directed to implement, monitor, and enforce the Compliance Program.

Section 4. These actions are effective upon the date of adoption of this Resolution.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima, this 5th day of December 2019.

AYES:
NOES:
ABSENT:
ABSTAIN:

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/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost, M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

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Orange County Health Authority
dba CalOptima

~~2019~~

2020 Compliance Plan

(Revised December ~~2018)~~2019)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Main: 714-246-~~8400~~8500 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, **Program of All-Inclusive Care for the Elderly (PACE)**, **Multipurpose Senior Services Program (MSSP)**, and other **CalOptima** ~~***programs***~~**Programs**.*

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's **First Tier**, **Downstream**, and **Related Entities** (**FDRs**), such as ~~***health networks***~~**Health Networks**, physician groups, ~~***participating providers***~~**Participating Providers, and** ~~***suppliers***~~~~, pharmacy benefit manager~~**Suppliers, Pharmacy Benefit Manager (PBM)**, and consultants. The term **FDR** is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the **Centers for Medicare & Medicaid Services** (**CMS**) and the **Department of Health Care Services** (**DHCS**). Such persons/entities, referred to as **FDR** herein, include those that directly contract with CalOptima and those that are **Downstream** or **Related Entities** (i.e., subcontracts) with CalOptima's **First Tier Entities**.

CalOptima has developed a comprehensive **Compliance Program** applicable to all of CalOptima's programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "**OneCare**"), its Medicare-Medicaid Plan (MMP referred to as "**OneCare Connect**"), **PACE**, and **MSSP**. The **Compliance Program** incorporates all ~~of the~~ elements of an effective **Compliance Program** as recommended by the **Office of the Inspector General** (**OIG**) and required by **CMS** regulations. The **Compliance Program** is continually evolving and may be modified and enhanced based on compliance ~~monitoring~~**Monitoring** and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that **CalOptima Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** conduct themselves in accordance with the requirements of CalOptima's **Compliance Program**.

B. THE COMPLIANCE PLAN

This **Compliance Plan** sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The **Compliance Plan** addresses the fundamental elements of an effective **Compliance Program** and identifies how CalOptima is implementing each of the fundamental elements of an effective **Compliance Program** in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the **Compliance Plan** is designed to provide guidance and to ensure that CalOptima's operations and the practices of its **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** comply with contractual requirements, ethical standards, and applicable law.

This **Compliance Plan** is adopted by the **Governing Body**. It was developed and is managed by the **Executive Director of Compliance** (hereinafter referred to ~~hereinafter~~ as the "**Compliance Officer**") with the **Compliance Committee**. ~~Because~~Due to the dynamic nature of the complex laws governing CalOptima and its programs ~~are constantly evolving~~, the **Compliance Plan** may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board ~~***members, employees***~~**Members, Employees**, and **FDRs** are expected to review and adhere to the requirements and standards set forth in the **Compliance Plan**, the **Code of Conduct**, and all related ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, as may be amended. Furthermore, **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a **Board** ~~***member, employee***~~**Member, Employee**, and/or **FDR** has/have any questions about the application, or implementation, of this **Compliance Plan**, or questions related to the **Code of Conduct** or CalOptima ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, he or she should seek guidance from the **Compliance Officer** and/or the CalOptima Office of Compliance.

I.WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**, CalOptima develops, maintains, and distributes its written standards in the form of this **Compliance Plan**, a separate **Code of Conduct**, and written ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**.

a. Compliance Plan

As noted above, this **Compliance Plan** outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to **CalOptima Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**. This **Compliance Plan** also includes a comprehensive section articulating CalOptima's commitment to preventing **Fraud**, **Waste**, & **Abuse** (**FWA**), and setting forth guidelines and procedures designed to detect, prevent, and remediate **FWA** in the administration of **CalOptima** ~~*programs*~~**Programs**. The **Compliance Plan** is available on CalOptima's external website for **Board** ~~*members*~~**Members** and **FDRs**, as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all ~~*employees*~~**Employees**.

b. Policies and Procedures

CalOptima also developed written ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** to address specific areas of CalOptima's operations, compliance activities, and **FWA** prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These ~~policies~~**Policies and Procedures** are designed to provide guidance to **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** are expected to be familiar with the ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The **Compliance Officer**, or his/her ~~*designee*~~**Designee**, will ensure that **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

The ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to CalOptima's ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**. **Policies and** ~~*procedures*~~**Procedures** are available on CalOptima's internal website and Compliance 360~~,~~ (C360), a separate web portal accessible to **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**. **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** receive notice when ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** are updated via a monthly memorandum.

c. Code of Conduct

Finally, the **Code of Conduct** is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the **Code of Conduct** is to articulate compliance expectations and broad principles that guide **CalOptima Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** in conducting their business activities in a professional, ethical, and lawful manner. The **Code of Conduct** is a separate document from the **Compliance Plan** and can be found in Appendix A. The **Code of Conduct** is approved by ~~CalOptima's~~the **CalOptima Board of Directors** and distributed to **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** upon appointment, hire, or the commencement of the contract, and annually thereafter. New **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** are required to sign an attestation acknowledging receipt and review of the **Code of Conduct** within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the **Compliance Program** requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by ~~CalOptima's~~the **CalOptima Board**, the **Compliance Officer**, the **Compliance Committee**, the **Audit & Oversight Committee**, and ~~***senior management***~~**Executive Staff**.

a. Governing Body

The **CalOptima Board of Directors**, as the **Governing Body**, is responsible for approving, implementing, and ~~monitoring~~**Monitoring** a **Compliance Program** governing CalOptima's operations. The **CalOptima Board** delegates the **Compliance Program** oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the **Compliance Officer**. The **Compliance Officer** is an ~~***employee***~~**Employee** of CalOptima, who handles compliance oversight and activities full-time. The **Compliance Officer**, in conjunction with the **Compliance Committee**, are both accountable for the oversight and reporting roles and responsibilities as set forth in this **Compliance Plan**. However, the **CalOptima Board** remains accountable for ensuring the effectiveness of the **Compliance Program** within CalOptima and ~~monitoring~~**Monitoring** the status of the **Compliance Program** to ensure its efficient and successful implementation.

To ensure the **CalOptima Board** exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's **Compliance Program**, the **CalOptima Board**:

- Understands the content and operation of CalOptima's **Compliance Program**;
- Approves the **Compliance Program**, including this **Compliance Plan** and the **Code of Conduct**;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the **Compliance Program** outcomes, including, but not limited to, results of internal and external ~~***audits***~~**Audits**;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the **Compliance Program**;
- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, **Corrective Action Plans**, Warning Letters, and/or ~~***sanctions***~~**Sanctions**;
- Receives regularly scheduled, periodic updates from CalOptima's **Compliance Officer** and **Compliance Committee**, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the **Compliance Program**.

The **CalOptima Board** reviews the measurable indicators of an effective **Compliance Program** and remains appropriately engaged in overseeing its efficient and successful implementation; however, the **CalOptima Board** delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The **Executive Director of Compliance** serves as the **Compliance Officer** who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the **Compliance Program**. The **Compliance Officer** reports directly to the CEO and the **Compliance Committee** on the activities and status of the **Compliance Program**. The **Compliance Officer** has authority to report matters directly to the **CalOptima Board** at any time. Furthermore, the **Compliance Officer** ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The **Compliance Officer** interacts with the **CalOptima Board**, CEO, CalOptima's ~~executive~~Executive Staff and departmental ~~management~~Management, **FDRs**, legal counsel, state and federal representatives, and others as required. In addition, the **Compliance Officer** supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, **FDR** and internal oversight, ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, and training on compliance activities.

The **CalOptima Board** delegates the following responsibilities to the **Compliance Officer**, and/or his/her ~~***designee***~~**Designee(s)**:

- Chair the **Compliance Committee**, which shall meet no less than quarterly and assists the **Compliance Officer** in fulfilling his/her responsibilities;
- Ensure that the **Compliance Program**, including this **Compliance Plan** and ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs**, as appropriate;
- Oversee and monitor the implementation of the **Compliance Program**, and provide regular reports no less than quarterly to the **CalOptima Board** and CEO summarizing all efforts, including, but not limited to, the **Compliance Committee**'s efforts to ensure adherence to the **Compliance Program**, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and ~~***audit***~~**Audit** activities;
- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential **FWA** received from any source through any reporting method;
- Design, coordinate, and/or conduct regular internal ~~***audits***~~**Audits** to ensure the **Compliance Program** is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of **Compliance Program** activities for each of CalOptima's programs, and regularly report CalOptima's progress in implementing those plans to the appropriate **Board** ~~Committee~~ committee and/or to the **Board of Directors**;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or **FWA** issues, including facilitating any documentation or procedural requests by such agency(s);
- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., **DHCS** and **CMS**) and consult with legal counsel, as necessary;

- Create and coordinate educational training programs and initiatives to ensure that the **CalOptima Board**, ~~***employees***~~**Employees**, and **FDRs** are knowledgeable about CalOptima's **Compliance Program**, including the **Code of Conduct**, ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, and all current and emerging applicable statutory and regulatory requirements;
- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate **Corrective Action Plans**, ~~***sanctions***~~**Sanctions**, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and **FDRs** to ensure ~~exclusion~~**Exclusion** and ~~preclusion~~**Preclusion** screening (including through the **OIG List of Excluded Individuals and Entities (LEIE)**, **General Services Administration (GSA) System for Award Management (SAM)**, ~~and~~ **Medi-Cal Suspended & Ineligible (S&I) Provider List**, and the **CMS Preclusion List**) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The **Compliance Committee**, chaired by the **Compliance Officer**, is composed of CalOptima's ~~***senior management***~~**Executive Staff** and operational staff, as designated by the CEO. The members of the **Compliance Committee** serve at the discretion of the CEO and may be removed, or added, at any time. The role of the **Compliance Committee** is to implement and oversee the **Compliance Program** and to participate in carrying out the provisions of this **Compliance Plan**. The **Compliance Committee** meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the **Compliance Program**.

The **CalOptima Board** delegates the following responsibilities to the **Compliance Committee**:

- Maintain and update the **Code of Conduct** consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the **CalOptima Board**;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of **Compliance Committee** meetings reflecting reports made to the **Compliance Committee** and the **Compliance Committee's** decisions on the issues raised (subject to all applicable privileges);
- Review and **Monitor** the effectiveness of the **Compliance Program**, including **Monitoring** key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the **Compliance Officer** to ensure the adequacy of the **Compliance Program**;
- Review, approve, and/or update ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** to ensure the successful implementation and effectiveness of the **Compliance Program** consistent with regulatory, legal, and contractual requirements;
- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the **Compliance Officer** accordingly;

- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of ~~*monitoring*~~**Monitoring** and ~~auditing~~**Auditing** of areas in which CalOptima is at risk of program non-compliance and/or potential **FWA**, and ensure **CAPs** and **ICAPs** are implemented and **Monitored** for effectiveness;
- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its **FDRs** conduct activities and operations in compliance with the applicable ~~law~~laws and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the **CalOptima Board of Directors**.

d. Audit & Oversight Committee (AOC)

The **Audit & Oversight Committee** (**AOC**) is a subcommittee of the **Compliance Committee** and is co-led by the Director(s) of Audit & Oversight. The **AOC** is responsible for overseeing the delegated and internal activities of CalOptima. The **Compliance Committee** has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee. In addition to the monthly scheduled meetings, the **AOC** may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the **AOC** are approved by the majority of a quorum of the **AOC**. A quorum is defined as one (1) over fifty percent (50%). **AOC** may approve and/or implement **Corrective Action Plans** (**CAPs**); however, recommendations for **FDR** ~~sanctioning~~**Sanctions** and/or de-~~*delegation*~~**Delegation** are submitted to the **Compliance Committee** for final approval. The **AOC** also contributes to external reviews and accreditation ~~*audits*~~**Audits**, such as the **National Committee for Quality Assurance** (**NCQA**).

Responsibilities of the **Audit & Oversight Committee** with regard to **FDRs** include:

- Annual review, revision, and approval of the ~~*audit*~~**Audit** tools;
- Review findings of the~~-~~ readiness assessment to evaluate a potential **FDR**'s ability to perform the delegated function(s);
- Review and approve potential **FDR** entities for ~~*delegation*~~**Delegation** of functions;
- Ensure written agreements with each delegated **FDR** clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and ~~monitoring~~**Monitoring** of **FDR** performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite ~~*audit*~~**Audit**;
- Ensure all **Downstream** and **Related Entities** are ~~monitored~~**Monitored** in accordance with CalOptima oversight procedures;
- Ensure that formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage **Corrective Action Plans** (**CAPs**) for compliance issues;
- Propose ~~*sanctions*~~**Sanctions**, subject to the **Compliance Committee's** approval, if an **FDR's** performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of ~~*delegation*~~**Delegation**, to the **Compliance Committee** for unresolved issues of compliance.

Responsibilities of the **Audit & Oversight Committee** ~~with regard to~~regarding internal business functions include:

- Annual review, revision, and approval of the ~~audit~~**Audit** work plan and ~~***audit***~~**Audit** tools;
- Conduct formal, ongoing evaluation and ~~monitoring~~**Monitoring** of internal business areas' performance and compliance through review of periodic reports submitted, ongoing ~~monitoring~~**Monitoring**, and findings of the annual ~~***audit***~~**Audit**;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage **Corrective Action Plans** (**CAPs**) for compliance issues.

~~**e. Senior Management**~~

- Initiate and manage other disciplinary actions (e.g., sanctions, de-delegation) for compliance issues.

e. Executive Staff

The CEO and ~~other executive management~~**Executive Staff** of CalOptima shall:

- Ensure that the **Compliance Officer** is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective **Compliance Program**;
- Receive periodic reports from the **Compliance Officer** of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including ~~***audit***~~**Audit** findings, ~~notices~~Notices of ~~non-compliance~~Non-Compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III. TRAINING

Education and training are critical elements of the **Compliance Program**. CalOptima requires that all **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's **Code of Conduct**, compliance obligations, ~~and~~ relevant laws, and **FWA**, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing ~~seniors~~**Seniors and** ~~people~~**People with** ~~disabilities~~**Disabilities (SPD)** and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the **Compliance Program**, and which courses are updated regularly to ensure that ~~*employees*~~**Employees** are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The **Compliance Officer,** or his/her ~~*designee*~~**Designee,** is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/**FDR's** completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The **Compliance Officer** and the CalOptima ~~management staff~~**Executive Staff** and **Management** are responsible for ensuring that **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's **Code of Conduct** to **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**. **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** are required to sign an attestation acknowledging receipt, review, and understanding of the **Code of Conduct** within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the **Code of Conduct** is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each individual's personnel file, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the **Compliance Program**; **FWA** training; **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the **Compliance Program** are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or **FWA** issues, along with CalOptima's policy on confidentiality, anonymity, and

non-retaliation for such reporting. CalOptima's **HIPAA** privacy and security training course covers the administrative, technical, and physical safeguards necessary to secure ~~***members'* protected health information~~**Members' Protected Health Information** **(PHI)** and ~~personally identifiable information~~**Personally Identifiable Information** **(PII)**.

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the **Compliance Program** requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each ~~***employee***~~**Employee**. **Board** ~~***members***~~**Members** and **FDRs** are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some **FDRs** may be exempt or deemed to have met the **FWA** training and education requirement if the **FDR** has met the **CMS** requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the **Compliance Program**. These training opportunities are available to ~~***managers***~~**Managers** and ~~***employees***~~**Employees** depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing ~~***managers***~~**Managers** the tools and resources to train and share the information with ~~***employees***~~**Employees** in their respective departments. If additional training related to **FWA** is required, the **Compliance Officer,** or his/her ~~***designee***~~**Designee,** will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** governing the **Compliance Program** and pertinent to their respective roles and responsibilities. **Employees** may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board ~~***members***~~**Members** receive a copy of the **Compliance Plan**, **Code of Conduct**, and ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the **CalOptima Board**. **Board** ~~***members***~~**Members** may receive additional compliance training related to the **CalOptima Board**'s role in overseeing and ensuring organizational compliance with CalOptima's **Compliance Program**.

The **Code of Conduct** and ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to **FDRs** upon commencement of the **FDR** contract. **FDRs** are required to disseminate copies of the **Code of Conduct** and ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** to their ~~***employees***~~**Employees**, agents, and/or **Downstream Entities**. CalOptima may also develop compliance training and education presentations and/or roundtables for specified **FDRs**.

IV.LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the **Compliance Program** and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**, contact information for the **Compliance Officer**, relevant federal and state ~~*fraud*~~**Fraud** alerts and policy letters, pending/new legislation reports, and advisory bulletins from the **Compliance Officer** to **CalOptima Board** ~~*members, employees*~~**Members, Employees**, **FDRs**, and ~~*members*~~**Members**, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the **CalOptima Board**, **FDRs**, ~~*employees,*~~ **Employees**, and individual CalOptima departments, and ~~*members.*~~ **Members.**
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**, which contains CalOptima's updated ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to **Board** ~~*members, employees*~~**Members, Employees**, **FDRs**, and ~~*members*~~**Members**.
- Electronic Mail – The CEO, **Compliance Officer**, or their respective ~~*designee*~~**Designee**, periodically sends out email communications and/or alerts to **Board** ~~*members, employees,*~~**Members, Employees**, and **FDRs**, and/or ~~*members*~~**Members**, as applicable.
- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to ~~*employees*~~**Employees**.
- CalOptima's Compliance Internal Website – The Office of Compliance maintains an internal department website accessible to CalOptima ~~*employees*~~**Employees** to communicate different Compliance initiatives, notices, key documents and forms, and updates to the **Compliance Program**, **Code of Conduct**, and/or ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and **FWA** throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima ~~*employees*~~**Employees**.
- Written Reports – The **Compliance Officer**, in coordination with the CEO and **Compliance Committee**, prepares written ~~monthly~~ reports~~.~~, no less than quarterly, concerning the status of the **Compliance Program** to be presented to the **CalOptima Board**.
- Direct Contact with the **Compliance Officer** - **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** can obtain additional compliance information directly from the **Compliance Officer**. Any questions, which cannot be answered by the **Compliance Officer**, shall be referred to the **Compliance Committee**.

b. Reporting Mechanisms

CalOptima Board ~~*members, employees*~~**Members, Employees**, and **FDRs** have an affirmative duty and are directed in CalOptima's **Code of Conduct** and ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by **Board** ~~*members, employees*~~**Members, Employees**, and/or

FDRs to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an **FDR** contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or **FWA** incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and **FWA** issues are also provided to **Board** ~~*members*~~, ~~*employees*~~**Members, Employees**, **FDRs**, and ~~*members*~~**Members** in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or **FWA**.

Upon receipt of a report through one (1) of the listed mechanisms, the **Compliance Officer**, or his/her ~~*designee*~~**Designee**, shall follow appropriate ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** to promptly review, investigate, and resolve such matters. The **Compliance Officer,** or his/her ~~*designee*~~**Designee**, shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to ~~a Supervisor~~Management or ~~Manager~~Executive Staff*

CalOptima ~~*employees*~~**Employees** are encouraged to contact their immediate ~~*supervisor*~~,**Management** or ~~*manager*~~,**Executive Staff** when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. ~~The *supervisor*~~,**Executive Staff** or ~~*manager*~~,**Management** will promptly escalate the report to the **Compliance Officer** for further investigation and reporting to the CalOptima **Compliance Committee**. If an ~~*employee*~~**Employee** is concerned that his/her ~~*supervisor*~~**Management** or ~~*manager*~~**Executive Staff** did not adequately address his/her report or complaint, the ~~*employee*~~**Employee** may go directly to the **Compliance Officer**, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with ~~Spanish and English capability~~multilingual support, in which CalOptima may receive anonymous issues on a confidential basis. **Members** are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or **FWA** issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all **Board** ~~*members*~~,

~~*employees*~~**Members, Employees**, **FDRs**, and ~~*members*~~**Members**. **Members** also have access to the **Compliance Officer** through the Compliance and Ethics Hotline and/or the right to contact the **OIG** Compliance Hotline (1-800-447-8477) directly.

3. *Report Directly to the Compliance Officer*

The **Compliance Officer** is available to receive reports of suspected or actual compliance violations, or **FWA** issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from **Board** ~~*members, employees*~~**Members, Employees**, **FDRs** and ~~*members*~~**Members**. The **Compliance Officer** may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. **FDRs** are generally contractually obligated to report suspected ~~*fraud*~~**Fraud** and ~~*abuse*~~**Abuse** to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or **FWA**, issues in good faith. This non-retaliation policy extends to reports received from **FDRs** and ~~*members*~~**Members**. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic ~~member~~**Member** notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the **Compliance Officer** will review and enforce disciplinary and/or other **Corrective Action Plans** for violations, as appropriate, with the approval of the **Compliance Committee**.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board ~~*members, employees*~~**Members, Employees**, and **FDRs** are provided copies of CalOptima's **Code of Conduct** and the **Compliance Plan** and have access on CalOptima's internal and external website to applicable ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards and Office of Compliance Policies addressing **Corrective Action Plans** and ~~*sanctions*~~**Sanctions**. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board ~~*members, employees*~~**Members, Employees**, and **FDRs** are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the **Compliance Program** documents and related ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**, including CalOptima Policy GA.8022: Performance and Behavior Standards, as applicable. **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's **Compliance Program** and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in **Federal and/or State** ~~*health care programs*~~**Health Care Programs**;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** and/or contracts; or
- Failure to report violations or suspected violations of the **Compliance Program**, or applicable laws, or to report suspected or actual **FWA** issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates **HIPAA** and other privacy laws and/or CalOptima's **HIPAA** privacy and security policies, including actions that harm the privacy of ~~*members*~~**Members**, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the **Compliance Program** shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, ~~*sanctions*~~**Sanctions**, and/or termination, depending on the nature and severity of the conduct, or behavior. **Board** ~~*members*~~**Members** may be subject to removal, ~~*employees*~~**Employees** are subject to discipline, up to and including termination, and **FDRs** may be sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative ~~*sanctions*~~**Sanctions** and/or penalties. Further violations could lead to suspension,

~~preclusion~~**Preclusion**, or ~~exclusion~~**Exclusion**, from participation in **Federal and/or State** ~~***health care programs***~~**Health Care Programs**.

CalOptima ~~***employees***~~**Employees** shall be evaluated annually based on their compliance with CalOptima's **Compliance Program**. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** are identified through a combination of activities: risk assessments, **Audit & Oversight Committee** and **Compliance Committee** discussions and decisions, and internal and external reporting. Through ~~monitoring, auditing~~**Monitoring, Auditing**, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The **Compliance Officer,** or his/her ~~***designee***~~**Designee,** will collaborate with the **Compliance Committee** to identify areas of focus for ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** potential non-compliant activity and **FWA** issues. A **Compliance Risk Assessment** will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of **FDRs**. Operations and processes will be evaluated based on: (1) deficiencies found by ~~regulatory agencies~~**Regulatory Agencies**; (2) deficiencies found by internal and external ~~***audit***~~**Audit** and ~~***monitoring***~~**Monitoring** reports; (3) the institution of new or updated ~~procedures~~**Policies and Procedures**; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by **CMS** and the **OIG** Work Plan shall be used as resources to evaluate operational risks.

The **Compliance Officer,** or his/her ~~***designee***~~**Designee,** will work with the Chief Operating Officer, or his/her ~~***designee***~~**Designee**, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and ~~auditing~~**Auditing**. Those operational areas determined to be high risk may be subject to more frequent ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing**, as well as additional reporting requirements. The risk assessment process will be managed by the **Compliance Officer**, or his/her ~~***designee***~~**Designee**, and presented to the **AOC**, and subsequently to the **Compliance Committee**, for review and approval. **Monitoring** plans will be developed in collaboration with the operational areas, and focused ~~***audits***~~**Audits** may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine ~~auditing~~**Auditing** and ~~***monitoring activities***~~**Monitoring Activities** to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima ~~***policies***~~**Policies** **and** ~~***procedures***~~**Procedures** to protect against non-compliance and potential **FWA** in **CalOptima** ~~***programs***~~**Programs**. CalOptima and **FDRs** shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. **Monitoring** ~~***activities***~~**Activities** are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An ~~***audit***~~**Audit** is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a ~~particular~~ set of standards (e.g., ~~***policies***~~**Policies** **and** ~~***procedures***~~**Procedures**, laws, and regulations) used as base measures. As part of the ~~monitoring~~**Monitoring** process, CalOptima has created a dashboard, which is a

~~monitoring~~**Monitoring** tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with ~~monitoring~~**Monitoring** operations and outcomes and to identify areas in need of targeted ~~auditing~~**Auditing** on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** work plans. **Monitoring** and ~~auditing~~**Auditing** work plans are used to detect potential areas of risk and/or non-compliant activity. The ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** work plans are subject to daily updates and additions, and are therefore, working documents. The **Compliance Officer**, or his/her ~~***designee***~~**Designee,** in collaboration with the **AOC** and **Compliance Committee**, develops the ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** work plans to address the risks associated with each of **CalOptima's** ~~***programs***~~**Programs**.

The **Compliance Officer,** or his/her ~~***designee***~~**Designee,** will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate ~~auditing~~**Auditing** and ~~***monitoring activities***~~**Monitoring Activities**. **Audits** for each operational area will be conducted throughout the year consistent with the ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** work plans. The **Compliance Officer**, or his/her ~~***designee***~~**Designee,** will coordinate the ~~***audits***~~**Audits** with internal audit staff, and, in some cases, with the assistance from an outside vendor. **Audit** methodologies shall be consistent with regulatory and **NCQA** requirements and standards. All ~~***audits***~~**Audits** will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the ~~***audit***~~**Audit** review is completed, the ~~***audit team***~~Audit & Oversight teams will communicate the results to the **Compliance Officer** and propose follow up corrective action(s), if necessary. The **Compliance Officer,** or his/her ~~***designee***~~**Designee,** will provide reports to the CEO and the **Compliance Committee** concerning the results of the ~~***audits***~~**Audits**. The **AOC** reports to the **Compliance Officer** and the **Compliance Committee** on ~~***audits***~~**Audits** that involve **FDRs** as discussed below. If **FWA** issues are identified during an ~~***audit***~~**Audit**, the matter will be further investigated and resolved in a timely manner. In addition, an ~~***audit***~~**Audit** of the **Compliance Program** and its effectiveness should occur at least annually, and the results shall be reported to the **CalOptima Board**.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to **CMS**, **DHCS**, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** process of **FDRs** who perform delegated activities. The processes that CalOptima implements to oversee, ~~monitor~~**Monitor**, and ~~***audit***~~**Audit** **FDRs** are incorporated into CalOptima's written ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, including processes involving pre-contractual evaluations and ~~***audits***~~**Audits** of **First Tier Entities**. CalOptima may implement **Corrective Action Plans**, ~~***sanctions***~~**Sanctions**, and/or revoke its ~~***delegation***~~**Delegation** of duties (in a manner permitted under the contract) if CalOptima determines that an **FDR** is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The **Compliance Officer**, or his/her ~~***designee***~~**Designee**, determines the process for ~~monitoring~~**Monitoring** delegated **FDRs** and develops the annual ~~monitoring~~**Monitoring** and ~~***audit***~~**Audit** calendar in order to ~~validPate~~validate compliance with contractual standards and regulatory requirements. The **AOC** is responsible for overseeing all of the delegated activities and will review the readiness assessment, ensure the annual review of **FDRs** for delegated functions are

completed, conduct formal on-going evaluation of **FDR** performance and compliance, ensure **Downstream** and **Related Entities** are monitored, and impose **Corrective Action Plans** and/or ~~*sanctions*~~**Sanctions** if the **FDR**'s performance fails to meet statutory and contractual standards and requirements. The **AOC** may recommend termination of ~~*delegation*~~**Delegation** to the **Compliance Committee** for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or ~~*delegation*~~**Delegation** agreement with a potential **FDR**, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**, is completed to determine the ability of the potential **FDR** to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, **CMS**, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not ~~precluded~~**Precluded** on the **Preclusion List**, excluded in the **OIG List of Excluded Individuals/Entities (LEIE)**, the **General Services Administration (GSA) System of Award Management (SAM)**, or the ~~*DHCS*~~ **Medi-Cal Suspended & Ineligible (S&I) Provider** ~~Manual~~ **List** from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the **AOC** and subsequently the **Compliance Committee** for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the ~~*delegation*~~**Delegation** agreement specifies the activities CalOptima delegates to the **FDRs**, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and ~~*audits*~~**Audits**, and remedies, including disciplinary actions, available to CalOptima. Prior to any ~~*sub*~~**Sub-delegation** to any **Downstream** or **Related Entity**, a **First Tier Entity** must obtain approval from CalOptima. CalOptima determines who will directly monitor the **Downstream** or **Related Entity's** compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the **FDR** and their contractually delegated area(s). Furthermore, **FDRs** will be required to complete, sign, and return attestation forms confirming the **FDR**'s compliance with new hire and annual training and education requirements, which includes courses on general compliance and **FWA** as well as ~~exclusion~~**Exclusion** and ~~preclusion~~**Preclusion** screening and **FWA** reporting obligations.

3. *Annual Risk Assessment*

The **Compliance Officer**, or his/her ~~*designee*~~**Designee**, will ensure that an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate) to determine the **FDR's** vulnerabilities and high-risk areas. High-risk **FDRs** are those that are continually non-compliant or at risk of non-compliance based on identified gaps in

processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any **FDR** deemed high risk, or vulnerable, is presented to the **AOC** for suggested follow-up ~~*audit*~~**Audit**. **FDRs** determined to be high risk may be subjected to a more frequent ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** schedule, as well as additional reporting requirements. The risk assessment process, along with reports from **FDRs**, will be managed by the **Compliance Officer**, or his/her ~~*designee*~~**Designee**, and presented to the **AOC** and subsequently to the **Compliance Committee** for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the **FDR's** ability to provide delegated services in accordance with contractual standards and applicable state, **CMS**, and accreditation requirements, as further detailed in CalOptima's ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**. CalOptima may conduct ~~*audits*~~**Audits** of **FDRs** at any time. Such ~~*audits*~~**Audits** may include an evaluation of the **FDR's** training and education program and materials covering general compliance and **FWA**, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk **FDRs**, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual ~~*audit*~~**Audit** calendar; however, CalOptima does not limit its ~~auditing~~**Auditing** schedule to only high-risk **FDRs**.

If CalOptima has reason to believe the **FDR's** ability to perform a delegated function is compromised, an additional focused ~~*audit*~~**Audit** may be performed. The **Compliance Officer,** or his/her ~~*designee*~~**Designee**, may also recommend focused ~~*audits*~~**Audits** upon evaluation of non-compliant trends or reported incidents. The results of these ~~*audits*~~**Audits** will be reported to the **AOC** and then to the **Compliance Committee**.

A focused ~~*audit*~~**Audit** may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or CalOptima's service level performance indicators;
- Failure to comply with a **Corrective Action Plan**;
- Reported or alleged ~~*fraud, waste*~~**Fraud, Waste**, and/or ~~*abuse*~~**Abuse**;
- Significant policy variations that deviate from the CalOptima or state, **CMS**, or accreditation requirements;
- Bankruptcy, or impending bankruptcy, which may impact services to ~~*members*~~**Members** (either suspected or reported);
- Sale, merger, or acquisition involving the **FDR**;
- Significant changes in the management of the **FDR**; and/or
- Changes in resources which impact CalOptima's and/or the **FDR's** operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The **Compliance Officer,** or his/her ~~*designee*~~**Designee**, shall submit regular reports of all monitoring, ~~*audit*~~**Audit**, and corrective action activities to the **Compliance Committee**. In instances where non-compliance is identified, a **Corrective Action Plan** shall be developed by the

FDR and reviewed and approved by the **Compliance Officer**, or his/her ~~*designee*~~**Designee**. Every **Corrective Action Plan** is presented to the AOC, in aggregate, with no less than quarterly updates, and recommendations for ~~review.~~escalation, as applicable. Supplemental and focused ~~*audits*~~**Audits** of **FDRs**, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement ~~*sanctions*~~**Sanctions** or require remediation by an **FDR** for failure to fulfill contractual obligations including development and implementation of a **Corrective Action Plan**. Failure to cooperate with CalOptima in any manner may result in termination of the ~~*delegation*~~**Delegation** agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's ~~auditing~~**Auditing** process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the ~~auditing~~**Auditing** processes, including ~~*policies*~~**Policies** **and** ~~*procedures*~~, ~~*audit*~~**Procedures, Audit** tools, and ~~*audit*~~**Audit** findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- The central database of all pending, active, and terminated **FDRs** to monitor and track functions, performance, and ~~*audit*~~**Audit** schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of ~~*audit*~~**Audit** tools;
- Implementation of a process for noticing **FDRs** and functional areas of **Corrective Action Plans**;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding ~~*delegation*~~**Delegation** standards, ~~auditing~~**Auditing**, and ~~monitoring~~**Monitoring** **FDR** performance; and/or
- Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of **FDR** performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight ~~*audits*~~**Audits** completed within twelve (12) months; and
- **Corrective Action Plans** (**CAPs**) completed within the established time frame.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's ~~*policies*~~**Policies** **and** ~~*procedures*~~**Procedures**, CalOptima performs **Participation Status Reviews** by ~~reviewing~~searching the **OIG –LEIE**, the **GSA–SAM**, the **DHCS Medi-Cal Suspended & Ineligible Provider Lists**, and the **CMS Preclusion List** upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure

Board ~~*members, employees*~~**Members, Employees**, and/or **FDRs** are not excluded, or do not become excluded or precluded from participating in **Federal and/or State** ~~*health care programs.*~~**Health Care Programs**. **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** are required to disclose their ~~*participation status*~~**Participation Status** as part of their initial appointment, employment, commencement of the contract and registration/application processes and when **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** receive notice of a suspension, ~~preclusion, exclusion~~**Preclusion, Exclusion**, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its **First Tier Entities** comply with **Participation Status Review** requirements with respect to their relationships with **Downstream Entities**, including without limitation, the delegated credentialing and re-credentialing processes.

The **Compliance Officer,** or his/her ~~*designee*~~**Designee,** will review reports from ~~*employees*~~**Employees** responsible for conducting the **Participation Status Reviews** to ensure ~~*employees*~~**Employees** record and maintain the results of the reviews and notices/disclosures. **Employees** shall immediately notify the **Compliance Officer**, or his/her **Designee,** of affirmative findings of a person, or entity's, failure to meet the **Participation Status Review** requirements. If CalOptima learns that any prospective, or current, **Board** ~~*member, employee*~~**Member, Employee**, or **FDR** has been proposed for ~~exclusion, excluded~~**Exclusion, Excluded**, or ~~precluded~~**Precluded**, CalOptima will promptly remove him/her/the **FDR** from **CalOptima's** ~~*programs*~~**Programs** consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of their suspension, ~~exclusion~~**Exclusion**, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the **CMS Preclusion List**, consistent with regulatory guidance, applicable policies, and/or contract terms. The **Compliance Officer,** or his/her ~~*designee*~~**Designee**, will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII.RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's **Compliance Program** and/or **FWA** issues, the **Compliance Officer,** or his/her ~~***designee***~~**Designee**, shall, upon promptly verifying the facts related to the violation or likely violation, notify the **Compliance Committee**, as appropriate. The **Compliance Committee** (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, ~~***sanctions***~~**Sanctions**, termination of any agreement and/or any other corrective action ~~(including repayment of ***overpayments***)~~ consistent with applicable ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, subject to consultation with legal counsel and/or notifying the **Governing Body**, as appropriate;
- Implementing education and training programs for **Board** ~~***members, employees***~~**Members, Employees**, and/or **FDRs**, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's **Compliance Plan**, **Code of Conduct**, and/or relevant ~~***policies***~~**Policies and** ~~***procedures*** in an effort~~**Procedures** to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the **Compliance Officer** and the **Compliance Committee** to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** after considering such recommendations. The **Compliance Officer**, or his/her ~~***designee***, shall~~**Designee**, may monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to **DHCS** Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning ~~***fraud***~~**Fraud** schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims activity indicates that ~~***fraud***~~**Fraud** may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a ~~*fraud*~~**Fraud** alert is received, CalOptima shall review its ~~*delegation*~~**Delegation** agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the ~~*delegation*~~**Delegation** agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a ~~*fraud*~~**Fraud** alert. With the issuance of a ~~*fraud*~~**Fraud** alert, **CMS** places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party ~~needs~~need to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged ~~*fraud*~~**Fraud** scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes ~~member~~**Member** complaints, **DHCS** Audits and Investigations referrals, MEDIC investigations, **OIG** and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of **Federal and/or State** ~~*health care programs*~~**Health Care Programs** requirements. CalOptima shall also maintain files that contain documented warnings (e.g., ~~*fraud*~~**Fraud** alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, **DHCS**, **CMS**, and **CMS'** ~~*designee*~~**Designee**, regarding ~~monitoring~~**Monitoring** of **FDRs** within CalOptima's network that **DHCS**, or **CMS**, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent **FWA** within a **CalOptima** ~~program~~**Program**. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of **FWA** activity. CalOptima shall assess all **FDRs** for potential ~~*overpayments*~~**Overpayments** when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return ~~*overpayments*~~**Overpayments** consistent with applicable laws and regulatory guidance. ~~Should revisions to reported data be~~

As required, CalOptima and/or the **FDR** shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of ~~*overpayment*~~**Overpayment** determinations to ~~regulatory agencies~~**Regulatory Agencies**, as required by law.

When applicable, CalOptima shall return **Overpayments** made to CalOptima, consistent with applicable state and federal laws and regulatory guidance.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of **FWA** are components of CalOptima's **Compliance Program**. **FWA** activities are implemented and overseen by CalOptima's **Compliance Officer,** or his/her ~~***designee***~~**Designee,** in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for **FWA** investigations. The **Compliance Officer,** or his/her ~~***designee***~~**Designee**, reports **FWA** activities to the CalOptima **Compliance Committee**, CEO, the **CalOptima Board**, and ~~regulatory agencies~~**Regulatory Agencies**.

CalOptima utilizes various resources to detect, prevent, and remediate **FWA**. In addition, CalOptima promptly investigates suspected **FWA** issues and ~~implements~~may implement disciplinary, or corrective, action to avoid recurrence of **FWA** issues. ~~–~~The objective of the **FWA** program is to ensure that the scope of benefits covered by the **CalOptima** ~~***programs***~~**Programs** is appropriately delivered to ~~***members***~~**Members** and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify **FWA** and promptly respond appropriately to such incidents of **FWA**.

I.FWA TRAINING

As detailed above, **FWA** training is provided to all **Board** ~~*members*~~**Members** and ~~*employees*~~**Employees** as part of the overall compliance training courses in order to help detect, prevent, and remediate **FWA**. **FDRs** are also required to complete **FWA** training, as described above. CalOptima's **FWA** training provides guidance to **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** on how to identify activities and behaviors that would constitute **FWA** and how to report suspected, or actual, **FWA** activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual **FWA**;
- Examples of the most common types of member **FWA** (see Appendix B, attached hereto and incorporated herein) and **FDR FWA** (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify **FWA** in **CalOptima** ~~*programs*~~**Programs** (e.g., suspicious activities suggesting CalOptima ~~members~~**Members**, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the **CalOptima** ~~*programs*~~**Programs**, etc.);
- Information on how to identify potential prescription drug **FWA** (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average ~~member~~**Member** in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential **FWA** using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for **FDRs**, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the **False Claims Act** and CalOptima's requirement to train ~~*employees*~~**Employees** and **FDRs** on the **False Claims Act** and other applicable **FWA** laws.

CalOptima shall provide **Board** ~~*members, employees*~~**Members, Employees**, **FDRs**, and ~~*members*~~**Members** with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with ~~the Regulatory Affairs & Compliance Department~~CalOptima internal departments, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of **FWA**. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. **Members**, **FDRs**, ~~*employees*~~**Employees**, law enforcement and ~~regulatory agencies~~**Regulatory Agencies,** and others ~~are able to~~may contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect **FWA** include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record ~~*audits*~~**Audits**;
- **Member** and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- **Auditing** and ~~*monitoring activities*~~**Monitoring Activities**;
- Monitoring external health care **FWA** cases and determining if CalOptima's **FWA** Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and ~~*audits*~~**Audits**.

b. Data Analytics

CalOptima uses technology and data analysis to reduce **FWA** externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect **FDRs** based on billing patterns.

CalOptima also uses the services of an external **Medicare Secondary Payer (MSP)** ~~vendor~~**Vendor** to reduce costs associated with its Medicare-Medicaid programs, such as the **OneCare**, **OneCare Connect**, and/or **PACE** programs, by ensuring that ~~Federal~~federal and ~~State~~state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data ~~is~~are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or ~~audited~~**Audited**. Any medical claim can be pended and reviewed in accordance with applicable state or federal law if they meet certain ~~criterion~~criteria that ~~warrants~~warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with

applicable state or federal law based on criteria focused on the types of drugs (~~for example~~e.g., narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the **PBM** will conduct data mining activities in order to identify potential issues of **FWA**.

The following trends will be reviewed and flagged for potential **FWA**, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual ~~Coding~~coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by ~~***members***~~**Members** and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected **FWA**. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the **PBM** will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or ~~makes arrangements~~arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a ~~***member***~~**Member** is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.

- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides ~~a number of~~several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a ~~member~~**Member** the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of **FWA**. The presence of several indicators may suggest **FWA**, but further investigation is needed to determine if a suspicion of **FWA** ~~actually~~ exists. The following list below highlights common industry indicators and red flags that are used to determine whether ~~or not~~ to investigate an **FDR** or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the ~~*member*~~**Member**/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the **FWA** database and a report is generated and submitted to the **Compliance Officer**, **Compliance Committee**, and CEO.

III.FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected **FWA** or detects **FWA** through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (~~Access~~access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an **FDR** to obtain relevant information;
- SIU, or a ~~***designee***~~**Designee**, interviews the individual who reported the **FWA**, affected ~~***members***~~**Members** and/or **FDRs**, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of **FDR** enrollment applications, history, and ownership, as necessary;
- Review of ~~member~~**Member** enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation ~~shall~~may be ~~forwarded~~reported to the **Compliance Officer** and **Compliance Committee**. If a CalOptima internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the **Compliance Committee** for ~~discussion and approval~~further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of **FWA**, need for contract amendment, education and training requirement, recommendation of focused ~~***audits***~~**Audits**, additional investigation, continued ~~monitoring~~**Monitoring**, new policy implementation, and/or criminal or civil action. When the root cause of the potential **FWA** issue has been identified, the SIU will track and trend the **FWA** allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the **Compliance Committee** on a quarterly basis. Investigation findings can be used to determine whether ~~or not~~ disciplinary, or corrective, action is appropriate, whether there is a need for

a change in CalOptima's ~~*policies*~~**Policies** **and** ~~*procedures*~~**Procedures**, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima ~~*policies*~~**Policies** **and** ~~*procedures*~~**Procedures**, CalOptima shall take appropriate disciplinary, or corrective, action against **Board** ~~*members, employees*~~**Members, Employees**, and/or **FDRs** related to validated instances of **FWA**. CalOptima will also assess **FDRs** for potential ~~*overpayments*~~**Overpayments** when reviewing and undertaking corrective actions. Corrective actions will be monitored by the **Compliance Committee**, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial ~~*sanctions*~~**Sanctions**, regulatory reporting, **Corrective Action Plans**, or termination of the ~~*delegation*~~**Delegation** agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, ~~CalOptima~~CalOptima's Office of Compliance will initiate review and discussion at the first **Compliance Committee** following the date of identification of the suspected **FWA**, the date of report to **DHCS**, or the date of **FWA** substantiation by **DHCS** subsequent to the report. If vulnerability is identified through a single **FWA** incident, the ~~correction~~corrective action may be applied universally.

b. Referral ~~T~~to Enforcement Agencies

CalOptima's SIU shall coordinate timely referrals of potential **FWA** to appropriate ~~regulatory agencies~~**Regulatory Agencies**, or their designated program integrity contractors, including the **CMS** MEDIC, **DHCS** Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. **FDRs** shall report **FWA** to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected **FWA**, should be reported to **CMS** and/or **DHCS**, as soon as possible after discovery, but no later than ten (10) working days to **DHCS** after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a **OneCare**, **OneCare Connect**, or **PACE** case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of **FWA**;
- Patterns of **FWA** threatening the life, or well-being, of CalOptima ~~*members*~~**Members**; and/or
- Schemes with large financial risk to CalOptima, or its ~~*members*~~**Members**.

IV.ANNUAL FWA EVALUATION

CalOptima's **Compliance Committee** shall periodically review and evaluate the **FWA** activities and its effectiveness as part of the overall **Compliance Program** ~~*audit*~~**Audit** and ~~*monitoring activities*~~**Monitoring Activities**. Revisions should be made based on industry changes, trends in **FWA** activities (locally and nationally), the **OIG** Work Plan, the CalOptima **Compliance Plan**, and other input from applicable sources.

a. Retention of Records

CalOptima shall maintain reports and summaries of **FWA** activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of ~~member~~**Member** records containing **PHI** in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of **FWA** investigations in a secure and confidential manner, regardless of the outcome of an investigation.

b. Confidentiality

CalOptima and its **FDRs** shall maintain all information associated with suspected, or actual, **FWA** in confidential files, which may only be released in accordance with applicable laws and CalOptima ~~*policies*~~**Policies** **and** ~~*procedures*~~**Procedures**. All participants and attendees of CalOptima's Quality Improvement Committee, **Compliance Committee**, and respective subcommittees~~,~~ shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the **Compliance Program**, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the **Compliance Program** against the elements of an effective **Compliance Program** as recommended by **OIG** and required by **CMS** regulations. The following areas will be reviewed:

- **Policies and** ~~***procedures***~~**Procedures**;
- **Compliance Officer** and **Compliance Committee**;
- Training and education of **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs**;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing**;
- **Delegation** oversight;
- **Exclusion** and ~~preclusion~~**Preclusion** screening process; and
- Prompt responses to detected offenses.

The **Compliance Program** will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with ~~***senior management***~~**Executive Staff and Management**, the **Compliance Committee**, and the **CalOptima Board**. Updates to the **Compliance Program** will be based on the results of the evaluation and will be referred to the **CalOptima Board** for review and approval.

I.PRIVILEGED FILES AND DOCUMENT RETENTION

I.Privileged FILING SYSTEMS

The ***Compliance Officer,*** or his/her ***designee,*** shall establish and maintain a filing system (or systems) for all compliance-related documents. The following files shall be established at CalOptima (as applicable):

a. Compliance Plan, Code of Conduct, and Policies and Procedures File

This file shall contain copies of the following (unless originals specified):

- ***Compliance Plan*** and any amendments;
- Any ***Compliance Program policies and procedures*** issued after the initiation of the ***Compliance Program***;
- Reports to, and Resolutions/Minutes of CalOptima's Board approving the Compliance Program, ***Compliance Plan***, ***Code of Conduct*** and/or appointment of the ***Compliance Officer***;

a. Files

- All non-privileged communications to the ***Compliance Officer*** (original);
- All ***Compliance Committee*** and ***CalOptima Board*** minutes in which compliance issues are discussed; and/or
- Any other written records of the ***AOC***, or other oversight activities (originals if generated by the ***Compliance Officer***).

b. Information and Education File

files

This file shall contain copies of the following (unless originals specified):

- ***FDR*** training and attestation records (including attendance records, Affirmation Statements, and the outline of topics covered);
- ***Board member*** and ***employee*** training records, attestations, and attendance records are maintained by the Human Resources Department.
- Educational materials provided to ***Board members***, ***employees***, and ***FDRs***;
- Notices, ***fraud*** alerts, and/or federal and state laws and regulations which have been posted on bulletin boards, placed in payroll stuffers, or sent via print or electronic communication (and the dates and locations of such notices); and/or
- All other written records of training activities.

c. Monitoring, Enforcement, and Response File

This file shall contain copies of the following (unless originals specified):

- Records relating to compliance reports including reports to the Compliance and Ethics Hotline and/or to the ***Compliance Officer*** (originals);
- Records relating to periodic monitoring and auditing of the ***Compliance Program*** (originals);

- ~~Records relating to ***Board member***, ***employee***, and ***FDR Participation Status*** Review or background checks (originals except where ***FDRs*** perform ***Participation Status*** Reviews);~~
- ~~Records relating to established periodic monitoring mechanisms;~~
- ~~All documents pertaining to the enforcement of the ***Compliance Program***, including, investigations and disciplinary and/or corrective actions; and/or~~
- ~~All documents reflecting actions taken after an offense has been detected, and all efforts to deter and prevent future violations.~~

~~**d. Privileged File**~~

~~This file~~ shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. ~~-~~Only the **Compliance Officer**, CalOptima legal counsel, and the **Compliance Committee**, where appropriate, shall have access to its contents. ~~-~~All ~~material~~materials in ~~this~~the privileged file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. ~~-This~~The privileged file ~~contains~~shall contain the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the **Compliance Officer**;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning **FDR delegation** agreement interpretations and remedies available to CalOptima.

~~e.~~b. Document Retention

~~All of the documents to be maintained in the filing system described above shall be retained~~CalOptima shall retain contracts, books, documents, records, financial statements, and other data, as defined in Title 42, Code of Federal Regulations, Sections 438.5(c), 438.604, 606, 608, and 610, for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). ~~-~~Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract~~.~~ (except for privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

CalOptima shall maintain the documentation required by **HIPAA** for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by **HIPAA**; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under **HIPAA**; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A



Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste, and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste, and abuse. CalOptima is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of potential fraud, waste, and abuse and discuss employee and contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

Principle	Standard
	Political Activities CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment

Principle	Standard
	and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its physician groups, its health networks and third-party administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima policies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.

Principle	Standard
Public Integrity CalOptima and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima policies. **Public Funds** CalOptima, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and employees shall comply with applicable law and CalOptima policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures.

Principle	Standard
	Personnel Files Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima.

Principle	Standard
	Third-Party Sponsored Events CalOptima's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima policies on this subject. In no event, shall CalOptima participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at contractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.

Principle	Standard
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, and gender expression), sexual orientation, health status, physical or mental disability, or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, physician groups, and health networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of employees, individuals and entities doing business with CalOptima by conducting regular exclusion and preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its health networks, physician groups, and third--party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Principle	Standard
	Licensure CalOptima requires that all employees, contractors, health networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own policies in accordance with CalOptima's reporting policies and its Compliance Plan. Such reports may be made to a supervisor or the Compliance Officer. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's

Principle	Standard
	discretion, range from oral correction to termination in accordance with CalOptima's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or exclusion or preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, employees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable policies.

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Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a covered service for purposes other than the purpose for which it was described including use of such covered service.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.	Hotline reports; internal reports; reports by health networks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for covered services that are substantially and demonstrably in excess of any individual's usual charges for such covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for covered services that are in excess of the quantity that is medically necessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for covered services that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for covered services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for covered services that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for covered services.	Member report; hotline report; oversight audits.
P09	Billing a member for covered services without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits.
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.
P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight audit; report by regulatory body; hotline.

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P13	False certification of medical necessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate minimum standards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; hotline report; oversight audits.
P20	Durable Medical Equipment- covered services that are not actually provided to member.	Member report; hotline report; oversight audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a member's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

Appendix E

AFFIRMATION STATEMENTS

CalOptima
AFFIRMATION STATEMENT-SUPERVISORS

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

I understand that it is my responsibility to respond to questions from employees under my direct supervision regarding the Compliance Plan, Code of Conduct, or applicable Policies and Procedures. If I am unable to respond to questions from employees under my direct supervision, I will refer them to the Compliance Officer. In addition, I understand that if an employee under my direct supervision reports a violation or suspected violation of CalOptima's Compliance Program to me, I will escalate and report the issue to the Compliance Officer.

By signature below, I also certify that I have completed the Compliance Training as indicated:

I attended the initial Compliance Training Session on _____.

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

Back to Agenda

CalOptima

AFFIRMATION STATEMENT-EMPLOYEES

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures specific to my job duties and responsibilities as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the Compliance Training Session on _____:

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-FDRs

I have received and read a copy of the Compliance Plan, Code of Conduct, and applicable Policies and Procedures relevant to the delegated activities, and I understand, acknowledge, and agree to abide by its contents and requirements.

I will disseminate the Compliance Plan, Code of Conduct, and applicable Policies and Procedures to those employees and agents who will furnish items or services to CalOptima under the Contractor Agreement.

_____
Print Name

_____
Signature

_____
Title

_____
Company

_____
Date

SIGN, DATE AND RETURN TO CalOptima SUPERVISOR

CalOptima

AFFIRMATION STATEMENT-BOARD MEMBERS

I have received and read a copy of the Compliance Plan, the Code of Conduct, and applicable Policies and Procedures, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the initial or regular training as indicated:

I attended the initial Compliance Training Session on _____.

I attended the annual Compliance Training Session on _____.

_____

Print Name

_____

Signature

_____

Date

RETURN TO THE COMPLIANCE OFFICER

E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit" or "Auditing") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one (1) of several acknowledged certifications.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director of Audit & Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima ~~members~~Members" or "~~members~~Members") means a beneficiary who is enrolled in a CalOptima program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima under contract with DHCS and CMS, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of ~~senior management staff~~**Executive Staff** that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, employees and FDRs comply with applicable law and ethical standards.

Compliance Risk Assessment ("CRA") A tool utilized to stratify level of risk (high, medium, low) based upon audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance

organizations licensed under the Knox-Keene Act, Health & Safety Code Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or **Employees** ("Employee" or "Employees") means any and all employees of CalOptima, including all ~~senior management~~Executive Staff, Management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

Exclusion ("Exclusion" or "Excluded") means suspension, exclusion, or debarment from participation in Federal and/or state health care programs.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

Executive Staff ("Executive Staff") means an employee whose position title is Chief, or Executive Director of one (1) or more departments.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State ~~health care programs~~Health Care Programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement,

acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a member under a CalOptima program.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

General Services Administration ("GSA") **System for Award Management** ("SAM") is a type of federal government exclusion database and contains the list of Excluded Parties List System (GSA-EPLS). The EPLS consists of federal contractors who have been debarred, sanctioned, or excluded due to government contract issues or fraud. The database is updated usually on a monthly basis.

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network ~~or Health Networks~~ ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Immediate Corrective Action Plan ("ICAP") means the result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Management ("Management") means any employee whose position title is Director, Senior Manager, Manager, or Supervisor of one (1) or more departments.

Medi-Cal Suspended & Ineligible ("S&I") **Provider List** is a list of suspended and ineligible providers that is maintained by DHCS in the Medi-Cal Provider Manual. The list is updated monthly and available online and in print from DHCS.

Medicare Secondary Payer (MSP) Vendor means third-party vendors contracted to perform administrative functions with regards to the identification and recovery of monies owed to OneCare or OneCare Connect for recoupment of conditional payments. These administrative duties include, but are not limited to, the pursuit of repayments for third party liabilities and other health care coverage.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Multipurpose Senior Services Program ("MSSP") is a program approved under the federal

Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of Inspector General List of Excluded Individuals and Entities ("OIG LEIE") is an exclusion list and contains individuals and/or entities that have been excluded from participation in federal healthcare programs such as Medicare and Medicaid. This list is usually updated on a monthly basis.

OneCare ("OneCare") is a Medicare Advantage Health Maintenance Organization (HMO) plan offered by CalOptima to provide Medicare covered benefits to Members.

OneCare Connect ("OneCare Connect") is a Medicare-Medicaid health plan offered by CalOptima that contracts with both Medicare and Medi-Cal to provide covered benefits of both programs to Members.

Overpayment ("Overpayment") means a payment disbursed in excess of amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating ~~providers~~**Providers and** ~~suppliers ("participating providers~~**Suppliers** ("Participating Providers and ~~suppliers~~Suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its health networks for items or services furnished to members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima policies and procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board ~~members~~Members, employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs.

Personally Identifiable Information ("PII") means any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Pharmacy Benefit Manager ("PBM") means an entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing

formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written policies and procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Program of All-Inclusive Care for the Elderly ("PACE") is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

Preclusion ("Precluded" or "Preclusion List") is a type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Protected Health Information ("PHI") refers to the 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

Regulatory Agencies ("Regulatory Agencies") include, but are not limited to: Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG), and the Office of Civil Rights (OCR).

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.

~~Senior Management ("Senior Management") means any employee whose position title is Chief Officer, Executive Director, or Director of one (1) or more departments.~~

Seniors and Persons with Disabilities ("SPD") means Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

Sub-delegation ("Sub-delegation") means the process by which a first tier entity expressly grants, by formal agreement, to a downstream entity the authority to carry out one or more functions that would otherwise be required to be performed by the first tier entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an employee in a position representing CalOptima who has one (1) or more employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima employee that is the designated liaison for that contractor.

Third–Party Administrator ("TPA") means a contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Orange County Health Authority
dba CalOptima

2020 Compliance Plan

(Revised December 2019)

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, **Program of All-Inclusive Care for the Elderly (PACE)**, **Multipurpose Senior Services Program (MSSP)**, and other **CalOptima Programs**.*

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's **First Tier**, **Downstream**, and **Related Entities** (**FDRs**), such as **Health Networks**, physician groups, **Participating Providers, and Suppliers**, **Pharmacy Benefit Manager (PBM)**, and consultants. The term **FDR** is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the **Centers for Medicare & Medicaid Services** (**CMS**) and the **Department of Health Care Services** (**DHCS**). Such persons/entities, referred to as **FDR** herein, include those that directly contract with CalOptima and those that are **Downstream** or **Related Entities** (i.e., subcontracts) with CalOptima's **First Tier Entities**.

CalOptima has developed a comprehensive **Compliance Program** applicable to all of CalOptima's programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "**OneCare**"), its Medicare-Medicaid Plan (MMP referred to as "**OneCare Connect**"), **PACE**, and **MSSP**. The **Compliance Program** incorporates all elements of an effective **Compliance Program** as recommended by the **Office of the Inspector General** (**OIG**) and required by **CMS** regulations. The **Compliance Program** is continually evolving and may be modified and enhanced based on compliance **Monitoring** and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that **CalOptima Board Members**, **Employees**, and **FDRs** conduct themselves in accordance with the requirements of CalOptima's **Compliance Program**.

B. THE COMPLIANCE PLAN

This **Compliance Plan** sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The **Compliance Plan** addresses the fundamental elements of an effective **Compliance Program** and identifies how CalOptima is implementing each of the fundamental elements of an effective **Compliance Program** in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the **Compliance Plan** is designed to provide guidance and to ensure that CalOptima's operations and the practices of its **Board Members**, **Employees**, and **FDRs** comply with contractual requirements, ethical standards, and applicable law.

This **Compliance Plan** is adopted by the **Governing Body**. It was developed and is managed by the **Executive Director of Compliance** (hereinafter referred to as the "**Compliance Officer**") with the **Compliance Committee**. Due to the dynamic nature of the complex laws governing CalOptima and its programs, the **Compliance Plan** may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board Members, **Employees**, and **FDRs** are expected to review and adhere to the requirements and standards set forth in the **Compliance Plan**, the **Code of Conduct**, and all related **Policies and Procedures**, as may be amended. Furthermore, **Board Members**, **Employees**, and **FDRs** are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a **Board Member**, **Employee**, and/or **FDR** has/have any questions about the application, or implementation, of this **Compliance Plan**, or questions related to the **Code of Conduct** or CalOptima **Policies and Procedures**, he or she should seek guidance from the **Compliance Officer** and/or the CalOptima Office of Compliance.

I.WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of **Board Members**, **Employees**, and **FDRs**, CalOptima develops, maintains, and distributes its written standards in the form of this **Compliance Plan**, a separate **Code of Conduct**, and written **Policies and Procedures**.

a. Compliance Plan

As noted above, this **Compliance Plan** outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to **CalOptima Board Members**, **Employees**, and **FDRs**. This **Compliance Plan** also includes a comprehensive section articulating CalOptima's commitment to preventing **Fraud**, **Waste**, & **Abuse** (**FWA**), and setting forth guidelines and procedures designed to detect, prevent, and remediate **FWA** in the administration of **CalOptima Programs**. The **Compliance Plan** is available on CalOptima's external website for **Board Members** and **FDRs,** as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all **Employees**.

b. Policies and Procedures

CalOptima also developed written **Policies and Procedures** to address specific areas of CalOptima's operations, compliance activities, and **FWA** prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These **Policies and Procedures** are designed to provide guidance to **Board Members**, **Employees**, and **FDRs** concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. **Board Members**, **Employees**, and **FDRs** are expected to be familiar with the **Policies and Procedures** pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The **Compliance Officer**, or his/her **Designee**, will ensure that **Board Members**, **Employees**, and **FDRs** are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

The **Policies and Procedures** are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's **Policies and Procedures** are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to CalOptima's **Policies and Procedures**. **Policies and Procedures** are available on CalOptima's internal website and Compliance 360 (C360), a separate web portal accessible to **Board Members**, **Employees**, and **FDRs**. **Board Members**, **Employees**, and **FDRs** receive notice when **Policies and Procedures** are updated via a monthly memorandum.

c. Code of Conduct

Finally, the **Code of Conduct** is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the **Code of Conduct** is to articulate compliance expectations and broad principles that guide **CalOptima Board Members**, **Employees**, and **FDRs** in conducting their business activities in a professional, ethical, and lawful manner. The **Code of Conduct** is a separate document from the **Compliance Plan** and can be found in Appendix A. The **Code of Conduct** is approved by the **CalOptima Board of Directors** and distributed to **Board Members**, **Employees**, and **FDRs** upon appointment, hire, or the commencement of the contract, and annually thereafter. New **Board Members**, **Employees**, and **FDRs** are required to sign an attestation acknowledging receipt and review of the **Code of Conduct** within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the **Compliance Program** requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by the **CalOptima Board**, the **Compliance Officer**, the **Compliance Committee**, the **Audit & Oversight Committee**, and **Executive Staff**.

a. Governing Body

The **CalOptima Board of Directors**, as the **Governing Body**, is responsible for approving, implementing, and **Monitoring** a **Compliance Program** governing CalOptima's operations. The **CalOptima Board** delegates the **Compliance Program** oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the **Compliance Officer**. The **Compliance Officer** is an **Employee** of CalOptima, who handles compliance oversight and activities full-time. The **Compliance Officer**, in conjunction with the **Compliance Committee**, are both accountable for the oversight and reporting roles and responsibilities as set forth in this **Compliance Plan**. However, the **CalOptima Board** remains accountable for ensuring the effectiveness of the **Compliance Program** within CalOptima and **Monitoring** the status of the **Compliance Program** to ensure its efficient and successful implementation.

To ensure the **CalOptima Board** exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's **Compliance Program**, the **CalOptima Board**:

- Understands the content and operation of CalOptima's **Compliance Program**;
- Approves the **Compliance Program**, including this **Compliance Plan** and the **Code of Conduct**;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the **Compliance Program** outcomes, including, but not limited to, results of internal and external **Audits**;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the **Compliance Program**;
- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, **Corrective Action Plans**, Warning Letters, and/or **Sanctions**;
- Receives regularly scheduled, periodic updates from CalOptima's **Compliance Officer** and **Compliance Committee**, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the **Compliance Program**.

The **CalOptima Board** reviews the measurable indicators of an effective **Compliance Program** and remains appropriately engaged in overseeing its efficient and successful implementation; however, the **CalOptima Board** delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The **Executive Director of Compliance** serves as the **Compliance Officer** who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the **Compliance Program**. The **Compliance Officer** reports directly to the CEO and the **Compliance Committee** on the activities and status of the **Compliance Program**. The **Compliance Officer** has authority to report matters directly to the **CalOptima Board** at any time. Furthermore, the **Compliance Officer** ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The **Compliance Officer** interacts with the **CalOptima Board**, CEO, CalOptima's Executive Staff and departmental Management, **FDRs**, legal counsel, state and federal representatives, and others as required. In addition, the **Compliance Officer** supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, **FDR** and internal oversight, **Policies and Procedures**, and training on compliance activities.

The **CalOptima Board** delegates the following responsibilities to the **Compliance Officer**, and/or his/her **Designee(s)**:

- Chair the **Compliance Committee**, which shall meet no less than quarterly and assists the **Compliance Officer** in fulfilling his/her responsibilities;
- Ensure that the **Compliance Program**, including this **Compliance Plan** and **Policies and Procedures**, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected **Board Members**, **Employees**, and **FDRs**, as appropriate;
- Oversee and monitor the implementation of the **Compliance Program**, and provide regular reports no less than quarterly to the **CalOptima Board** and CEO summarizing all efforts, including, but not limited to, the **Compliance Committee**'s efforts to ensure adherence to the **Compliance Program**, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and **Audit** activities;
- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential **FWA** received from any source through any reporting method;
- Design, coordinate, and/or conduct regular internal **Audits** to ensure the **Compliance Program** is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of **Compliance Program** activities for each of CalOptima's programs, and regularly report CalOptima's progress in implementing those plans to the appropriate **Board** committee and/or to the **Board of Directors**;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or **FWA** issues, including facilitating any documentation or procedural requests by such agency(s);
- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., **DHCS** and **CMS**) and consult with legal counsel, as necessary;
- Create and coordinate educational training programs and initiatives to ensure that the **CalOptima Board**, **Employees**, and **FDRs** are knowledgeable about CalOptima's

Compliance Program, including the **Code of Conduct**, **Policies and Procedures**, and all current and emerging applicable statutory and regulatory requirements;

- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate **Corrective Action Plans**, **Sanctions**, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and **FDRs** to ensure **Exclusion** and **Preclusion** screening (including through the **OIG List of Excluded Individuals and Entities (LEIE)**, **General Services Administration (GSA) System for Award Management (SAM)**, **Medi-Cal Suspended & Ineligible (S&I) Provider List**, and the **CMS Preclusion List**) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The **Compliance Committee**, chaired by the **Compliance Officer**, is composed of CalOptima's **Executive Staff** and operational staff, as designated by the CEO. The members of the **Compliance Committee** serve at the discretion of the CEO and may be removed, or added, at any time. The role of the **Compliance Committee** is to implement and oversee the **Compliance Program** and to participate in carrying out the provisions of this **Compliance Plan**. The **Compliance Committee** meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the **Compliance Program**.

The **CalOptima Board** delegates the following responsibilities to the **Compliance Committee**:

- Maintain and update the **Code of Conduct** consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the **CalOptima Board**;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of **Compliance Committee** meetings reflecting reports made to the **Compliance Committee** and the **Compliance Committee's** decisions on the issues raised (subject to all applicable privileges);
- Review and **Monitor** the effectiveness of the **Compliance Program**, including **Monitoring** key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the **Compliance Officer** to ensure the adequacy of the **Compliance Program**;
- Review, approve, and/or update **Policies and Procedures** to ensure the successful implementation and effectiveness of the **Compliance Program** consistent with regulatory, legal, and contractual requirements;
- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and **Policies and Procedures** as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the **Compliance Officer** accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of **Monitoring** and **Auditing** of areas in which CalOptima is at risk of program non-compliance and/or potential **FWA**, and ensure **CAPs** and **ICAPs** are implemented and **Monitored** for effectiveness;

- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its **FDRs** conduct activities and operations in compliance with the applicable laws and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the **CalOptima Board of Directors**.

d. Audit & Oversight Committee (AOC)

The **Audit & Oversight Committee** (**AOC**) is a subcommittee of the **Compliance Committee** and is co-led by the Director(s) of Audit & Oversight. The **AOC** is responsible for overseeing the delegated and internal activities of CalOptima. The **Compliance Committee** has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee. In addition to the monthly scheduled meetings, the **AOC** may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the **AOC** are approved by the majority of a quorum of the **AOC**. A quorum is defined as one (1) over fifty percent (50%). **AOC** may approve and/or implement **Corrective Action Plans** (**CAPs**); however, recommendations for **FDR Sanctions** and/or de-**Delegation** are submitted to the **Compliance Committee** for final approval. The **AOC** also contributes to external reviews and accreditation **Audits**, such as the **National Committee for Quality Assurance** (**NCQA**).

Responsibilities of the **Audit & Oversight Committee** with regard to **FDRs** include:

- Annual review, revision, and approval of the **Audit** tools;
- Review findings of the readiness assessment to evaluate a potential **FDR**'s ability to perform the delegated function(s);
- Review and approve potential **FDR** entities for **Delegation** of functions;
- Ensure written agreements with each delegated **FDR** clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and **Monitoring** of **FDR** performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite **Audit**;
- Ensure all **Downstream** and **Related Entities** are **Monitored** in accordance with CalOptima oversight procedures;
- Ensure that formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage **Corrective Action Plans** (**CAPs**) for compliance issues;
- Propose **Sanctions**, subject to the **Compliance Committee's** approval, if an **FDR's** performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of **Delegation**, to the **Compliance Committee** for unresolved issues of compliance.

Responsibilities of the **Audit & Oversight Committee** regarding internal business functions include:

- Annual review, revision, and approval of the **Audit** work plan and **Audit** tools;
- Conduct formal, ongoing evaluation and **Monitoring** of internal business areas' performance and compliance through review of periodic reports submitted, ongoing **Monitoring**, and findings of the annual **Audit**;

- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage **Corrective Action Plans** (**CAPs**) for compliance issues.
- Initiate and manage other disciplinary actions (e.g., sanctions, de-delegation) for compliance issues.

e. Executive Staff

The CEO and **Executive Staff** of CalOptima shall:

- Ensure that the **Compliance Officer** is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective **Compliance Program**;
- Receive periodic reports from the **Compliance Officer** of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including **Audit** findings, Notices of Non-Compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III.TRAINING

Education and training are critical elements of the **Compliance Program**. CalOptima requires that all **Board Members**, **Employees**, and **FDRs** complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's **Code of Conduct**, compliance obligations, relevant laws, and **FWA**, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing **Seniors and People with Disabilities (SPD)** and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the **Compliance Program**, and which courses are updated regularly to ensure that **Employees** are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The **Compliance Officer,** or his/her **Designee,** is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/**FDR's** completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The **Compliance Officer** and the CalOptima **Executive Staff** and **Management** are responsible for ensuring that **Board Members**, **Employees**, and **FDRs** complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's **Code of Conduct** to **Board Members**, **Employees**, and **FDRs**. **Board Members**, **Employees**, and **FDRs** are required to sign an attestation acknowledging receipt, review, and understanding of the **Code of Conduct** within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the **Code of Conduct** is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each individual's personnel file, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires **Board Members**, **Employees**, and **FDRs**, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the **Compliance Program**; **FWA** training; **Health Insurance Portability and Accountability Act of 1996** (**HIPAA**) privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the **Compliance Program** are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or **FWA** issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's **HIPAA** privacy and security training course covers the administrative, technical, and physical safeguards necessary to secure **Members' Protected Health Information**

(PHI) and **Personally Identifiable Information (PII)**.

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the **Compliance Program** requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each **Employee**. **Board Members** and **FDRs** are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some **FDRs** may be exempt or deemed to have met the **FWA** training and education requirement if the **FDR** has met the **CMS** requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the **Compliance Program**. These training opportunities are available to **Managers** and **Employees** depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing **Managers** the tools and resources to train and share the information with **Employees** in their respective departments. If additional training related to **FWA** is required, the **Compliance Officer,** or his/her **Designee,** will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's **Policies and Procedures** governing the **Compliance Program** and pertinent to their respective roles and responsibilities. **Employees** may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board Members receive a copy of the **Compliance Plan**, **Code of Conduct**, and **Policies and Procedures** pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the **CalOptima Board**. **Board Members** may receive additional compliance training related to the **CalOptima Board**'s role in overseeing and ensuring organizational compliance with CalOptima's **Compliance Program**.

The **Code of Conduct** and **Policies and Procedures** pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to **FDRs** upon commencement of the **FDR** contract. **FDRs** are required to disseminate copies of the **Code of Conduct** and **Policies and Procedures** to their **Employees**, agents, and/or **Downstream Entities**. CalOptima may also develop compliance training and education presentations and/or roundtables for specified **FDRs**.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the **Compliance Program** and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to **Policies and Procedures**, contact information for the **Compliance Officer**, relevant federal and state **Fraud** alerts and policy letters, pending/new legislation reports, and advisory bulletins from the **Compliance Officer** to **CalOptima Board Members**, **Employees**, **FDRs**, and **Members**, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the **CalOptima Board**, **FDRs**, **Employees**, and individual CalOptima departments, and **Members**.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to **Board Members**, **Employees**, and **FDRs**, which contains CalOptima's updated **Policies and Procedures**.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to **Board Members**, **Employees**, **FDRs**, and **Members**.
- Electronic Mail – The CEO, **Compliance Officer**, or their respective **Designee**, periodically sends out email communications and/or alerts to **Board Members**, **Employees**, and **FDRs**, and/or **Members**, as applicable.
- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to **Employees**.
- CalOptima's Compliance Internal Website – The Office of Compliance maintains an internal department website accessible to CalOptima **Employees** to communicate different Compliance initiatives, notices, key documents and forms, and updates to the **Compliance Program**, **Code of Conduct**, and/or **Policies and Procedures**.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and **FWA** throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima **Employees**.
- Written Reports – The **Compliance Officer**, in coordination with the CEO and **Compliance Committee**, prepares written reports, no less than quarterly, concerning the status of the **Compliance Program** to be presented to the **CalOptima Board**.
- Direct Contact with the **Compliance Officer** - **Board Members**, **Employees**, and **FDRs** can obtain additional compliance information directly from the **Compliance Officer**. Any questions, which cannot be answered by the **Compliance Officer**, shall be referred to the **Compliance Committee**.

b. Reporting Mechanisms

CalOptima Board Members, **Employees**, and **FDRs** have an affirmative duty and are directed in CalOptima's **Code of Conduct** and **Policies and Procedures** to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by **Board Members**, **Employees**, and/or **FDRs** to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination

of employment, or termination of an **FDR** contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or **FWA** incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and **FWA** issues are also provided to **Board Members**, **Employees**, **FDRs**, and **Members** in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or **FWA**.

Upon receipt of a report through one (1) of the listed mechanisms, the **Compliance Officer**, or his/her **Designee**, shall follow appropriate **Policies and Procedures** to promptly review, investigate, and resolve such matters. The **Compliance Officer,** or his/her **Designee**, shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to Management or Executive Staff*

CalOptima **Employees** are encouraged to contact their immediate **Management** or **Executive Staff** when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. **Executive Staff** or **Management** will promptly escalate the report to the **Compliance Officer** for further investigation and reporting to the CalOptima **Compliance Committee**. If an **Employee** is concerned that his/her **Management** or **Executive Staff** did not adequately address his/her report or complaint, the **Employee** may go directly to the **Compliance Officer**, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with multilingual support, in which CalOptima may receive anonymous issues on a confidential basis. **Members** are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or **FWA** issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all **Board Members**, **Employees**, **FDRs**, and **Members**. **Members** also have access to the **Compliance Officer** through the Compliance and Ethics Hotline and/or the right to contact the **OIG** Compliance Hotline (1-800-447-8477) directly.

3. *Report Directly to the Compliance Officer*

The **Compliance Officer** is available to receive reports of suspected or actual compliance violations, or **FWA** issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from **Board Members**, **Employees**, **FDRs** and **Members**. The **Compliance Officer** may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. **FDRs** are generally contractually obligated to report suspected **Fraud** and **Abuse** to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or **FWA**, issues in good faith. This non-retaliation policy extends to reports received from **FDRs** and **Members**. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic **Member** notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the **Compliance Officer** will review and enforce disciplinary and/or other **Corrective Action Plans** for violations, as appropriate, with the approval of the **Compliance Committee**.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board Members, **Employees**, and **FDRs** are provided copies of CalOptima's **Code of Conduct** and the **Compliance Plan** and have access on CalOptima's internal and external website to applicable **Policies and Procedures**, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards and Office of Compliance Policies addressing **Corrective Action Plans** and **Sanctions**. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board Members, **Employees**, and **FDRs** are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the **Compliance Program** documents and related **Policies and Procedures**, including CalOptima Policy GA.8022: Performance and Behavior Standards, as applicable. **Board Members**, **Employees**, and **FDRs** may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's **Compliance Program** and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in **Federal and/or State Health Care Programs**;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, **Policies and Procedures** and/or contracts; or
- Failure to report violations or suspected violations of the **Compliance Program**, or applicable laws, or to report suspected or actual **FWA** issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates **HIPAA** and other privacy laws and/or CalOptima's **HIPAA** privacy and security policies, including actions that harm the privacy of **Members**, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the **Compliance Program** shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, **Sanctions**, and/or termination, depending on the nature and severity of the conduct, or behavior. **Board Members** may be subject to removal, **Employees** are subject to discipline, up to and including termination, and **FDRs** may be sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative **Sanctions** and/or penalties. Further violations could lead to suspension, **Preclusion**, or **Exclusion**, from participation in **Federal and/or State Health Care Programs**.

CalOptima **Employees** shall be evaluated annually based on their compliance with CalOptima's

Compliance Program. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

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VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with **Monitoring** and **Auditing** are identified through a combination of activities: risk assessments, **Audit & Oversight Committee** and **Compliance Committee** discussions and decisions, and internal and external reporting. Through **Monitoring**, **Auditing**, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The **Compliance Officer,** or his/her **Designee,** will collaborate with the **Compliance Committee** to identify areas of focus for **Monitoring** and **Auditing** potential non-compliant activity and **FWA** issues. A **Compliance Risk Assessment** will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of **FDRs**. Operations and processes will be evaluated based on: (1) deficiencies found by **Regulatory Agencies**; (2) deficiencies found by internal and external **Audit** and **Monitoring** reports; (3) the institution of new or updated **Policies and Procedures**; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by **CMS** and the **OIG** Work Plan shall be used as resources to evaluate operational risks.

The **Compliance Officer,** or his/her **Designee,** will work with the Chief Operating Officer, or his/her **Designee**, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and **Auditing**. Those operational areas determined to be high risk may be subject to more frequent **Monitoring** and **Auditing**, as well as additional reporting requirements. The risk assessment process will be managed by the **Compliance Officer**, or his/her **Designee**, and presented to the **AOC**, and subsequently to the **Compliance Committee**, for review and approval. **Monitoring** plans will be developed in collaboration with the operational areas, and focused **Audits** may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine **Auditing** and **Monitoring Activities** to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima **Policies and Procedures** to protect against non-compliance and potential **FWA** in **CalOptima Programs**. CalOptima and **FDRs** shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. **Monitoring Activities** are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An **Audit** is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a set of standards (e.g., **Policies and Procedures**, laws, and regulations) used as base measures. As part of the **Monitoring** process, CalOptima has created a dashboard, which is a **Monitoring** tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with **Monitoring** operations and outcomes

and to identify areas in need of targeted **Auditing** on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop **Monitoring** and **Auditing** work plans. **Monitoring** and **Auditing** work plans are used to detect potential areas of risk and/or non-compliant activity. The **Monitoring** and **Auditing** work plans are subject to daily updates and additions, and are therefore, working documents. The **Compliance Officer**, or his/her **Designee,** in collaboration with the **AOC** and **Compliance Committee**, develops the **Monitoring** and **Auditing** work plans to address the risks associated with each of **CalOptima's Programs**.

The **Compliance Officer,** or his/her **Designee,** will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate **Auditing** and **Monitoring Activities**. **Audits** for each operational area will be conducted throughout the year consistent with the **Monitoring** and **Auditing** work plans. The **Compliance Officer**, or his/her **Designee,** will coordinate the **Audits** with internal audit staff, and, in some cases, with the assistance from an outside vendor. **Audit** methodologies shall be consistent with regulatory and **NCQA** requirements and standards. All **Audits** will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the **Audit** review is completed, the Audit & Oversight teams will communicate the results to the **Compliance Officer** and propose follow up corrective action(s), if necessary. The **Compliance Officer,** or his/her **Designee,** will provide reports to the CEO and the **Compliance Committee** concerning the results of the **Audits**. The **AOC** reports to the **Compliance Officer** and the **Compliance Committee** on **Audits** that involve **FDRs** as discussed below. If **FWA** issues are identified during an **Audit**, the matter will be further investigated and resolved in a timely manner. In addition, an **Audit** of the **Compliance Program** and its effectiveness should occur at least annually, and the results shall be reported to the **CalOptima Board**.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to **CMS**, **DHCS**, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight **Monitoring** and **Auditing** process of **FDRs** who perform delegated activities. The processes that CalOptima implements to oversee, **Monitor**, and **Audit FDRs** are incorporated into CalOptima's written **Policies and Procedures**, including processes involving pre-contractual evaluations and **Audits** of **First Tier Entities**. CalOptima may implement **Corrective Action Plans**, **Sanctions**, and/or revoke its **Delegation** of duties (in a manner permitted under the contract) if CalOptima determines that an **FDR** is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The **Compliance Officer**, or his/her **Designee**, determines the process for **Monitoring** delegated **FDRs** and develops the annual **Monitoring** and **Audit** calendar in order to validate compliance with contractual standards and regulatory requirements. The **AOC** is responsible for overseeing all of the delegated activities and will review the readiness assessment, ensure the annual review of **FDRs** for delegated functions are completed, conduct formal on-going evaluation of **FDR** performance and compliance, ensure **Downstream** and **Related Entities** are monitored, and impose **Corrective Action Plans** and/or **Sanctions** if the **FDR**'s performance fails to meet statutory and contractual standards and requirements. The **AOC** may recommend termination of **Delegation** to the **Compliance Committee** for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or **Delegation** agreement with a potential **FDR**, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's **Policies and Procedures**, is completed to determine the ability of the potential **FDR** to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, **CMS**, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not **Precluded** on the **Preclusion List**, excluded in the **OIG List of Excluded Individuals/Entities (LEIE)**, the **General Services Administration (GSA) System of Award Management (SAM)**, or the **Medi-Cal Suspended & Ineligible (S&I) Provider List** from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the **AOC** and subsequently the **Compliance Committee** for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the **Delegation** agreement specifies the activities CalOptima delegates to the **FDRs**, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and **Audits**, and remedies, including disciplinary actions, available to CalOptima. Prior to any **Sub-delegation** to any **Downstream** or **Related Entity**, a **First Tier Entity** must obtain approval from CalOptima. CalOptima determines who will directly monitor the **Downstream** or **Related Entity's** compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the **FDR** and their contractually delegated area(s). Furthermore, **FDRs** will be required to complete, sign, and return attestation forms confirming the **FDR**'s compliance with new hire and annual training and education requirements, which includes courses on general compliance and **FWA** as well as **Exclusion** and **Preclusion** screening and **FWA** reporting obligations.

3. *Annual Risk Assessment*

The **Compliance Officer**, or his/her **Designee**, will ensure that an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate) to determine the **FDR's** vulnerabilities and high-risk areas. High-risk **FDRs** are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any **FDR** deemed high risk, or vulnerable, is presented to the **AOC** for suggested follow-up **Audit**. **FDRs** determined to be high risk may be subjected to a more frequent **Monitoring** and **Auditing** schedule, as well as additional reporting requirements. The risk assessment process, along with reports from **FDRs**, will be managed by the **Compliance Officer**, or his/her **Designee**, and presented to the **AOC**

and subsequently to the **Compliance Committee** for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the **FDR's** ability to provide delegated services in accordance with contractual standards and applicable state, **CMS**, and accreditation requirements, as further detailed in CalOptima's **Policies and Procedures**. CalOptima may conduct **Audits** of **FDRs** at any time. Such **Audits** may include an evaluation of the **FDR's** training and education program and materials covering general compliance and **FWA**, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk **FDRs**, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual **Audit** calendar; however, CalOptima does not limit its **Auditing** schedule to only high-risk **FDRs**.

If CalOptima has reason to believe the **FDR's** ability to perform a delegated function is compromised, an additional focused **Audit** may be performed. The **Compliance Officer,** or his/her **Designee**, may also recommend focused **Audits** upon evaluation of non-compliant trends or reported incidents. The results of these **Audits** will be reported to the **AOC** and then to the **Compliance Committee**.

A focused **Audit** may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or CalOptima's service level performance indicators;
- Failure to comply with a **Corrective Action Plan**;
- Reported or alleged **Fraud**, **Waste**, and/or **Abuse**;
- Significant policy variations that deviate from the CalOptima or state, **CMS**, or accreditation requirements;
- Bankruptcy, or impending bankruptcy, which may impact services to **Members** (either suspected or reported);
- Sale, merger, or acquisition involving the **FDR**;
- Significant changes in the management of the **FDR**; and/or
- Changes in resources which impact CalOptima's and/or the **FDR's** operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The **Compliance Officer,** or his/her **Designee**, shall submit regular reports of all monitoring, **Audit**, and corrective action activities to the **Compliance Committee**. In instances where non-compliance is identified, a **Corrective Action Plan** shall be developed by the **FDR** and reviewed and approved by the **Compliance Officer**, or his/her **Designee**. Every **Corrective Action Plan** is presented to the AOC, in aggregate, with no less than quarterly updates, and recommendations for escalation, as applicable. Supplemental and focused **Audits** of **FDRs**, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement **Sanctions** or require remediation by an **FDR** for failure to fulfill contractual obligations including development and implementation of a **Corrective Action Plan**. Failure to cooperate with CalOptima in any manner may result in termination of the **Delegation** agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's **Auditing** process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the **Auditing** processes, including **Policies and Procedures**, **Audit** tools, and **Audit** findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- The central database of all pending, active, and terminated **FDRs** to monitor and track functions, performance, and **Audit** schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of **Audit** tools;
- Implementation of a process for noticing **FDRs** and functional areas of **Corrective Action Plans**;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding **Delegation** standards, **Auditing**, and **Monitoring FDR** performance; and/or
- Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of **FDR** performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight **Audits** completed within twelve (12) months; and
- **Corrective Action Plans** (**CAPs**) completed within the established time frame.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's **Policies and Procedures**, CalOptima performs **Participation Status Reviews** by searching the **OIG –LEIE**, the **GSA–SAM**, the **DHCS Medi-Cal Suspended & Ineligible Provider Lists**, and the **CMS Preclusion List** upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure **Board Members**, **Employees**, and/or **FDRs** are not excluded, or do not become excluded or precluded from participating in **Federal and/or State Health Care Programs**. **Board Members**, **Employees**, and **FDRs** are required to disclose their **Participation Status** as part of their initial appointment, employment, commencement of the contract and registration/application processes and when **Board Members**, **Employees**, and **FDRs** receive notice of a suspension, **Preclusion**, **Exclusion**, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its **First Tier Entities** comply with **Participation Status Review** requirements with respect to their relationships with **Downstream Entities**, including without limitation, the delegated credentialing and re-credentialing processes.

The **Compliance Officer,** or his/her **Designee,** will review reports from **Employees** responsible for

conducting the **Participation Status Reviews** to ensure **Employees** record and maintain the results of the reviews and notices/disclosures. **Employees** shall immediately notify the **Compliance Officer**, or his/her **Designee,** of affirmative findings of a person, or entity's, failure to meet the **Participation Status Review** requirements. If CalOptima learns that any prospective, or current, **Board Member**, **Employee**, or **FDR** has been proposed for **Exclusion**, **Excluded**, or **Precluded**, CalOptima will promptly remove him/her/the **FDR** from **CalOptima's Programs** consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of their suspension, **Exclusion**, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the **CMS Preclusion List**, consistent with regulatory guidance, applicable policies, and/or contract terms. The **Compliance Officer,** or his/her **Designee**, will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII.RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's **Compliance Program** and/or **FWA** issues, the **Compliance Officer,** or his/her **Designee**, shall, upon promptly verifying the facts related to the violation or likely violation, notify the **Compliance Committee**, as appropriate. The **Compliance Committee** (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, **Sanctions**, termination of any agreement and/or any other corrective action consistent with applicable **Policies and Procedures**, subject to consultation with legal counsel and/or notifying the **Governing Body**, as appropriate;
- Implementing education and training programs for **Board Members**, **Employees**, and/or **FDRs**, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's **Compliance Plan**, **Code of Conduct**, and/or relevant **Policies and Procedures** to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the **Compliance Officer** and the **Compliance Committee** to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable **Policies and Procedures** after considering such recommendations. The **Compliance Officer**, or his/her **Designee**, may monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to **DHCS** Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning **Fraud** schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims activity indicates that **Fraud** may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a **Fraud** alert is received, CalOptima shall review its **Delegation** agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if

indictments have been issued against the particular parties and the terms of the **Delegation** agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a **Fraud** alert. With the issuance of a **Fraud** alert, **CMS** places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party need to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged **Fraud** scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes **Member** complaints, **DHCS** Audits and Investigations referrals, MEDIC investigations, **OIG** and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of **Federal and/or State Health Care Programs** requirements. CalOptima shall also maintain files that contain documented warnings (e.g., **Fraud** alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, **DHCS**, **CMS**, and **CMS' Designee**, regarding **Monitoring** of **FDRs** within CalOptima's network that **DHCS**, or **CMS**, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent **FWA** within a **CalOptima Program**. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of **FWA** activity. CalOptima shall assess all **FDRs** for potential **Overpayments** when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return **Overpayments** consistent with applicable laws and regulatory guidance.

As required, CalOptima and/or the **FDR** shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of **Overpayment** determinations to **Regulatory Agencies**, as required by law.

When applicable, CalOptima shall return **Overpayments** made to CalOptima, consistent with applicable state and federal laws and regulatory guidance.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of **FWA** are components of CalOptima's **Compliance Program**. **FWA** activities are implemented and overseen by CalOptima's **Compliance Officer,** or his/her **Designee,** in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for **FWA** investigations. The **Compliance Officer,** or his/her **Designee**, reports **FWA** activities to the CalOptima **Compliance Committee**, CEO, the **CalOptima Board**, and **Regulatory Agencies**.

CalOptima utilizes various resources to detect, prevent, and remediate **FWA**. In addition, CalOptima promptly investigates suspected **FWA** issues and may implement disciplinary, or corrective, action to avoid recurrence of **FWA** issues. The objective of the **FWA** program is to ensure that the scope of benefits covered by the **CalOptima Programs** is appropriately delivered to **Members** and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify **FWA** and promptly respond appropriately to such incidents of **FWA**.

I.FWA TRAINING

As detailed above, **FWA** training is provided to all **Board Members** and **Employees** as part of the overall compliance training courses in order to help detect, prevent, and remediate **FWA**. **FDRs** are also required to complete **FWA** training, as described above. CalOptima's **FWA** training provides guidance to **Board Members**, **Employees**, and **FDRs** on how to identify activities and behaviors that would constitute **FWA** and how to report suspected, or actual, **FWA** activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual **FWA**;
- Examples of the most common types of member **FWA** (see Appendix B, attached hereto and incorporated herein) and **FDR FWA** (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify **FWA** in **CalOptima Programs** (e.g., suspicious activities suggesting CalOptima **Members**, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the **CalOptima Programs**, etc.);
- Information on how to identify potential prescription drug **FWA** (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average **Member** in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential **FWA** using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for **FDRs**, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the **False Claims Act** and CalOptima's requirement to train **Employees** and **FDRs** on the **False Claims Act** and other applicable **FWA** laws.

CalOptima shall provide **Board Members**, **Employees**, **FDRs**, and **Members** with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with CalOptima internal departments, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of **FWA**. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. **Members**, **FDRs**, **Employees**, law enforcement and **Regulatory Agencies,** and others may contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect **FWA** include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record **Audits**;
- **Member** and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- **Auditing** and **Monitoring Activities**;
- Monitoring external health care **FWA** cases and determining if CalOptima's **FWA** Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and **Audits**.

b. Data Analytics

CalOptima uses technology and data analysis to reduce **FWA** externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect **FDRs** based on billing patterns.

CalOptima also uses the services of an external **Medicare Secondary Payer (MSP) Vendor** to reduce costs associated with its Medicare-Medicaid programs, such as the **OneCare**, **OneCare Connect**, and/or **PACE** programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or **Audited**. Any medical claim can be pended and reviewed in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and challenges previously

reported pertaining to certain pharmacies. CalOptima along with the **PBM** will conduct data mining activities in order to identify potential issues of **FWA**.

The following trends will be reviewed and flagged for potential **FWA**, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by **Members** and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected **FWA**. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the **PBM** will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a **Member** is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.

- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a **Member** the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of **FWA**. The presence of several indicators may suggest **FWA**, but further investigation is needed to determine if a suspicion of **FWA** exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an **FDR** or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the **Member**/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the **FWA** database and a report is generated and submitted to the **Compliance Officer**, **Compliance Committee**, and CEO.

III.FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected **FWA** or detects **FWA** through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an **FDR** to obtain relevant information;
- SIU, or a **Designee**, interviews the individual who reported the **FWA**, affected **Members** and/or **FDRs**, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of **FDR** enrollment applications, history, and ownership, as necessary;
- Review of **Member** enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the **Compliance Officer** and **Compliance Committee**. If a CalOptima internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the **Compliance Committee** for further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of **FWA**, need for contract amendment, education and training requirement, recommendation of focused **Audits**, additional investigation, continued **Monitoring**, new policy implementation, and/or criminal or civil action. When the root cause of the potential **FWA** issue has been identified, the SIU will track and trend the **FWA** allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the **Compliance Committee** on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's **Policies and Procedures**, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima **Policies and Procedures**, CalOptima shall take appropriate disciplinary, or corrective, action against **Board Members**, **Employees**, and/or **FDRs** related to validated instances of **FWA**. CalOptima will also assess **FDRs** for potential **Overpayments** when reviewing and undertaking corrective actions. Corrective actions will be monitored by the **Compliance Committee**, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial **Sanctions**, regulatory reporting, **Corrective Action Plans**, or termination of the **Delegation** agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima's Office of Compliance will initiate review and discussion at the first **Compliance Committee** following the date of identification of the suspected **FWA**, the date of report to **DHCS**, or the date of **FWA** substantiation by **DHCS** subsequent to the report. If vulnerability is identified through a single **FWA** incident, the corrective action may be applied universally.

b. Referral to Enforcement Agencies

CalOptima's SIU shall coordinate timely referrals of potential **FWA** to appropriate **Regulatory Agencies**, or their designated program integrity contractors, including the **CMS** MEDIC, **DHCS** Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. **FDRs** shall report **FWA** to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected **FWA**, should be reported to **CMS** and/or **DHCS**, as soon as possible after discovery, but no later than ten (10) working days to **DHCS** after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a **OneCare**, **OneCare Connect**, or **PACE** case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of **FWA**;
- Patterns of **FWA** threatening the life, or well-being, of CalOptima **Members**; and/or
- Schemes with large financial risk to CalOptima, or its **Members**.

IV.ANNUAL FWA EVALUATION

CalOptima's **Compliance Committee** shall periodically review and evaluate the **FWA** activities and its effectiveness as part of the overall **Compliance Program Audit** and **Monitoring Activities**. Revisions should be made based on industry changes, trends in **FWA** activities (locally and nationally), the **OIG** Work Plan, the CalOptima **Compliance Plan**, and other input from applicable sources.

a. Retention of Records

CalOptima shall maintain reports and summaries of **FWA** activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of **Member** records containing **PHI** in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of **FWA** investigations in a secure and confidential manner, regardless of the outcome of an investigation.

b. Confidentiality

CalOptima and its **FDRs** shall maintain all information associated with suspected, or actual, **FWA** in confidential files, which may only be released in accordance with applicable laws and CalOptima **Policies and Procedures**. All participants and attendees of CalOptima's Quality Improvement Committee, **Compliance Committee**, and respective subcommittees shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the **Compliance Program**, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the **Compliance Program** against the elements of an effective **Compliance Program** as recommended by **OIG** and required by **CMS** regulations. The following areas will be reviewed:

- **Policies and Procedures**;
- **Compliance Officer** and **Compliance Committee**;
- Training and education of **Board Members**, **Employees**, and **FDRs**;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal **Monitoring** and **Auditing**;
- **Delegation** oversight;
- **Exclusion** and **Preclusion** screening process; and
- Prompt responses to detected offenses.

The **Compliance Program** will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with **Executive Staff and Management**, the **Compliance Committee**, and the **CalOptima Board**. Updates to the **Compliance Program** will be based on the results of the evaluation and will be referred to the **CalOptima Board** for review and approval.

I.PRIVILEGED FILES AND DOCUMENT RETENTION

a. Privileged Files

All privileged files shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the **Compliance Officer**, CalOptima legal counsel, and the **Compliance Committee**, where appropriate, shall have access to its contents. All materials in the privileged file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. The privileged file shall contain the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the **Compliance Officer**;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning **FDR delegation** agreement interpretations and remedies available to CalOptima.

b. Document Retention

CalOptima shall retain contracts, books, documents, records, financial statements, and other data, as defined in Title 42, Code of Federal Regulations, Sections 438.5(c), 438.604, 606, 608, and 610, for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract (except for privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

CalOptima shall maintain the documentation required by **HIPAA** for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) **Policies and Procedures** (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by **HIPAA**; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under **HIPAA**; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A



Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste, and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste, and abuse. CalOptima is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of potential fraud, waste, and abuse and discuss employee and contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

Back to Agenda

Principle	Standard
	Political Activities CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment

Principle	Standard
	and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its physician groups, its health networks and third-party administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima policies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.

Principle	Standard
Public Integrity CalOptima and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima policies. **Public Funds** CalOptima, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and employees shall comply with applicable law and CalOptima policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures.

Principle	Standard
	Personnel Files Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima.

Principle	Standard
	Third-Party Sponsored Events CalOptima's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima policies on this subject. In no event, shall CalOptima participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at contractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.

Principle	Standard
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, and gender expression), sexual orientation, health status, physical or mental disability, or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, physician groups, and health networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of employees, individuals and entities doing business with CalOptima by conducting regular exclusion and preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its health networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Principle	Standard
	Licensure CalOptima requires that all employees, contractors, health networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own policies in accordance with CalOptima's reporting policies and its Compliance Plan. Such reports may be made to a supervisor or the Compliance Officer. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's

Principle	Standard
	discretion, range from oral correction to termination in accordance with CalOptima's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or exclusion or preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, employees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable policies.

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Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a covered service for purposes other than the purpose for which it was described including use of such covered service.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.	Hotline reports; internal reports; reports by health networks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

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Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for covered services that are substantially and demonstrably in excess of any individual's usual charges for such covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for covered services that are in excess of the quantity that is medically necessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for covered services that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for covered services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for covered services that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for covered services.	Member report; hotline report; oversight audits.
P09	Billing a member for covered services without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits.
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.

P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight audit; report by regulatory body; hotline.
FDR FRAUD, WASTE OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
P13	False certification of medical necessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate minimum standards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; hotline report; oversight audits.
P20	Durable Medical Equipment- covered services that are not actually provided to member.	Member report; hotline report; oversight audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a member's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit" or "Auditing") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one (1) of several acknowledged certifications.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director of Audit & Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima Members" or "Members") means a beneficiary who is enrolled in a CalOptima program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima under contract with DHCS and CMS, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of **Executive Staff** that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, employees and FDRs comply with applicable law and ethical standards.

Compliance Risk Assessment ("CRA") A tool utilized to stratify level of risk (high, medium, low) based upon audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance

organizations licensed under the Knox-Keene Act, Health & Safety Code Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or **Employees** ("Employee" or "Employees") means any and all employees of CalOptima, including all Executive Staff, Management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

Exclusion ("Exclusion" or "Excluded") means suspension, exclusion, or debarment from participation in Federal and/or state health care programs.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

Executive Staff ("Executive Staff") means an employee whose position title is Chief, or Executive Director of one (1) or more departments.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State Health Care Programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care

services to a member under a CalOptima program.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

General Services Administration ("GSA") **System for Award Management** ("SAM") is a type of federal government exclusion database and contains the list of Excluded Parties List System (GSA-EPLS). The EPLS consists of federal contractors who have been debarred, sanctioned, or excluded due to government contract issues or fraud. The database is updated usually on a monthly basis.

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Immediate Corrective Action Plan ("ICAP") means the result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Management ("Management") means any employee whose position title is Director, Senior Manager, Manager, or Supervisor of one (1) or more departments.

Medi-Cal Suspended & Ineligible ("S&I") **Provider List** is a list of suspended and ineligible providers that is maintained by DHCS in the Medi-Cal Provider Manual. The list is updated monthly and available online and in print from DHCS.

Medicare Secondary Payer (MSP) Vendor means third-party vendors contracted to perform administrative functions with regards to the identification and recovery of monies owed to OneCare or OneCare Connect for recoupment of conditional payments. These administrative duties include, but are not limited to, the pursuit of repayments for third party liabilities and other health care coverage.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Multipurpose Senior Services Program ("MSSP") is a program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature

institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of Inspector General List of Excluded Individuals and Entities ("**OIG LEIE"**) is an exclusion list and contains individuals and/or entities that have been excluded from participation in federal healthcare programs such as Medicare and Medicaid. This list is usually updated on a monthly basis.

OneCare ("OneCare") is a Medicare Advantage Health Maintenance Organization (HMO) plan offered by CalOptima to provide Medicare covered benefits to Members.

OneCare Connect ("OneCare Connect") is a Medicare-Medicaid health plan offered by CalOptima that contracts with both Medicare and Medi-Cal to provide covered benefits of both programs to Members.

Overpayment ("Overpayment") means a payment disbursed in excess of amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating Providers and Suppliers ("Participating Providers and Suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its health networks for items or services furnished to members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima policies and procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board Members, employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs.

Personally Identifiable Information ("PII") means any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Pharmacy Benefit Manager ("PBM") means an entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written policies and procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Program of All-Inclusive Care for the Elderly ("PACE") is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

Preclusion ("Precluded" or "Preclusion List") is a type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Protected Health Information ("PHI") refers to the 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

Regulatory Agencies ("Regulatory Agencies") include, but are not limited to: Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG), and the Office of Civil Rights (OCR).

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.

Seniors and Persons with Disabilities ("SPD") means Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

Sub-delegation ("Sub-delegation") means the process by which a first tier entity expressly grants, by formal agreement, to a downstream entity the authority to carry out one or more functions that would

otherwise be required to be performed by the first tier entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an employee in a position representing CalOptima who has one (1) or more employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima employee that is the designated liaison for that contractor.

Third-Party Administrator ("TPA") means a contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Attachment 3: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures, by department.

Department	Policy	Policy Title	Summary of Change(s)	Reason for Change(s)
Audit & Oversight - External	**HH.4001Δ**	Audit & Oversight Committee	▪ Incorporated clarifying language stating that should an AOC voting member designee serve as a subject matter expert at an AOC meeting, the designee will not have voting rights unless pre-approved by the AOC chairs.	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations
Audit & Oversight - Internal	**HH.4002**	CalOptima Internal Oversight	▪ Two components were added to the internal oversight responsibilities: data integrity reviews and validation reviews.	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations
Fraud, Waste, Abuse – Special Investigations Unit	**HH.1105Δ**	Fraud, Waste, and Abuse Detection	▪ Added language to outline the existing process to identify fraud and abuse of controlled substances by members, prescribing providers, and pharmacies. ▪ Added tables to detail the types of fraud that may be committed by a member or a First Tier, Downstream or Related Entity (FDR).	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations
Fraud, Waste, Abuse – Special Investigations Unit	**HH.1107Δ**	Fraud, Waste, and Abuse Investigation and Reporting	▪ Added reference to CalOptima Policy GG.1423: Medication Quality Assurance Program (revised in response to APL 19-012). ▪ Language incorporated into CalOptima Policy HH.1105Δ was removed to avoid redundancy.	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations

Department	Policy	Policy Title	Summary of Change(s)	Reason for Change(s)
Fraud, Waste, Abuse – Special Investigations Unit	**HH.5000Δ**	Provider Overpayment Investigation and Determination	▪ Included language to detail that during an overpayment investigation, the Special Investigations Unit (SIU) team may conduct interviews or surveys to verify if services were rendered, or appropriately billed. ▪ Added time frames for obtaining medical records from providers during an overpayment investigation.	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations
Privacy	**HH.3001Δ**	Member Access to Designated Record Set	▪ Added language detailing a member, or their personal representative's right to direct CalOptima to transmit Protected Health Information (PHI) directly to another entity. ▪ Included that the licensed health care professional involved in an appeal cannot be the same professional who made the original denial decision. ▪ Clarified that the Privacy Officer will consults with a licensed healthcare professional to determine appropriateness of member access to inspect or copy PHI from the Designated Record Set.	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations
Privacy	**HH.3006Δ**	Tracking and Reporting Disclosures of Protected Health Information (PHI)	▪ Removed language detailing the components of the log maintained for accounting of disclosures and referenced the appropriate CalOptima policy.	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations
Privacy	**HH.3015Δ**	Member Authorization for the Use and Disclosure of Protected Health Information (PHI)	▪ Included language referring to Office of Compliance's new form, 'Revocation of Authorization for Release of Protected Health Information.'	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations

Department	Policy	Policy Title	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	**HH.2005Δ**	Corrective Action Plan	▪ Revised language to allow flexibility for the Office of Compliance to issue an Immediate Corrective Action Plan (ICAP), when appropriate.	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations
Regulatory Affairs & Compliance	**HH.2014Δ**	Compliance Program	▪ Attachment A: 2019 Compliance Plan was revised for 2020. ▪ Attachment B: FDR Compliance Attestation [Update 04/19]	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations
Regulatory Affairs & Compliance	**HH.2021**Δ	Exclusion Monitoring	▪ Included appropriate references to non-contracted Providers throughout the policy. ▪ Revised grid outlining the responsible CalOptima department for verification of employee, FDR, or non-contracted provider, prior to contracting/hire/payment, and monthly thereafter. ▪ Added section detailing actions taken by CalOptima after discovery of preclusion.	Annual review to incorporate revisions to align with the 2020 Compliance Plan and current operations

Table 2: Office of Compliance Policies and Procedures: Non-substantive Revisions

The following table contains the proposed list of policies without substantive changes for the CalOptima Office of Compliance, by department.

Department	Policy	Policy Title	Summary of Change(s)	Reason for Change(s)
Audit & Oversight – External	**GG.1605**	Delegation and Oversight of Credentialing and Recredentialing Activities	▪ No substantive changes made since the 2018 annual review.	N/A
Audit & Oversight – External	**GG.1619**	Delegation Oversight	▪ No substantive changes made since the 2018 annual review.	N/A
Audit & Oversight – External	**HH.2015**	Health Network Claims Processing	▪ No substantive changes made since the 2018 annual review.	N/A
Audit & Oversight – External	**HH.2025**	Health Network Subdelegation and Subcontracting	▪ No substantive changes made since the 2018 annual review.	N/A

Department	Policy	Policy Title	Summary of Change(s)	Reason for Change(s)
Audit & Oversight – External	**HH.2026**	Claims Delegation and Oversight	▪ No substantive changes made since the 2018 annual review.	N/A
Audit & Oversight - External	**HH.2027**	Annual Risk Assessment (Delegate)	▪ No substantive changes made since the 2018 annual review.	N/A
Audit & Oversight - Internal	**HH.4003**	Annual Risk Assessment	▪ No substantive changes made since the 2018 annual review.	N/A
Fraud, Waste, Abuse – Special Investigations Unit	**HH.5004Δ**	False Claims Act Education	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3000Δ**	Notice of Privacy Practices	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3002Δ**	Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3003Δ**	Verification of Identity for Disclosure of Protected Health Information	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3004Δ**	Member Request to Amend Records	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3005Δ**	Member Request for Accounting of Disclosures	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3007Δ**	Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI)	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3008Δ**	Member Right to Request Confidential Communications	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3009Δ**	Access by Member's Authorized Representative	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3010Δ**	Protected Health Information (PHI) Disclosures Required by Law	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3011Δ**	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3014Δ**	Use of Electronic Mail with Protected Health Information (PHI)	▪ No substantive changes made since the 2018 annual review.	N/A

Department	Policy	Policy Title	Summary of Change(s)	Reason for Change(s)
Privacy	**HH.3016Δ**	Guidelines for Handling Protected Health Information (PHI) Offsite	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3019Δ**	De-identification of Protected Health Information (PHI)	▪ No substantive changes made since the 2018 annual review.	N/A
Privacy	**HH.3020Δ**	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI, or Other Unauthorized Use or Disclosure of PHI/PI	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2002Δ**	Sanctions	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2007Δ**	Compliance Committee	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2018Δ**	Compliance and Ethics Hotline	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2019Δ**	Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA) and Violations of Applicable Laws and Regulations and/or CalOptima Policies	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2020Δ**	Conducting Compliance Investigations	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2022Δ**	Record Retention and Access	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2023Δ**	Compliance Training	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2028Δ**	Code of Conduct	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2029Δ**	Annual Compliance Program Effectiveness Audit	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**HH.3012Δ**	Non-Retaliation for Reporting Violations	▪ No substantive changes made since the 2018 annual review.	N/A
Regulatory Affairs & Compliance	**MA.9124**	CMS Self-Disclosure	▪ No substantive changes made since the 2018 annual review.	N/A

Policy ~~#~~:	HH.4001Δ
Title:	**Audit & Oversight Committee**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	*Michael Schrader* _____
Effective Date:	09/01/~~15~~2015
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

FOR 20191205BOD REVIEW

I. PURPOSE

This policy identifies the functions and responsibilities of the **Audit & Oversight Committee (AOC)** responsible for oversight of CalOptima's internal departments and its **First Tier, Downstream, and Related Entities (FDRs)**.

II. POLICY

A. Oversight of delegated and internal operations is critical to CalOptima, ~~as~~ this process is mandated by, state and federal~~, state, regulatory contracts,~~ laws and regulations, program contracts, and accreditation standards, and is necessary to ensure sound fiscal practices, prevent **Fraud**, **Waste,** and **Abuse**, and the provision of quality health care to CalOptima **Members**.

III. PROCEDURE

~~A. Audit & Oversight Committee (AOC) members shall include the following CalOptima staff, serving either on a permanent, or interim, basis:~~

~~1. Executive Director, Operations;~~

~~2. Executive Director, Network Management;~~

~~3. Chief Financial Officer;~~

~~4. Chief Medical Officer;~~

~~5. Medical Director, Behavioral Health;~~

~~6. Executive Director, Compliance; and~~

~~7. Director, Pharmacy Management.~~

~~B.~~A. The Directors of Audit & Oversight shall serve as the ~~chair~~chairs of the **Audit & Oversight Committee (AOC)**.

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~~C.~~B. Each member of the **AOC** is a voting member. Voting **members** may appoint a **Designee**, ~~as~~when deemed appropriate. The **Designee** ~~shall~~may serve as a subject matter expert at the **AOC**~~.~~ meeting; however, the **Designee** will not have voting rights unless approved in advance by the chairs.

~~D.~~C. Establishment of Quorum

1. A quorum for the committee is based on majority. A quorum is required for **AOC** to take action on any agenda item.

~~2. There must be at least four (4) members, or their Designee of the AOC present, in addition to the chair, to establish a quorum.~~

~~3.~~2. In the absence of quorum, the meeting may proceed; however, any issues requiring a vote shall be deferred until the next regular meeting, or subject to an electronic vote.

~~E.~~D. CalOptima's **AOC** shall conduct the following activities:

1. Oversee the monitoring, auditing, and reporting processes for internal departments and identified **FDRs** including, but not limited to delegated **Health Networks**;

2. Provide oversight of internal departments and **FDRs** who perform applicable core administrative functions and/or health care services for any of CalOptima's programs by evaluating performance measures and audit findings;

3. Recommend sanctions upon ~~an~~ **FDRs** up to and including the revocation or termination of delegation if the delegated entity's performance is inadequate, in accordance with CalOptima Policy HH.2002Δ: Sanctions;

4. Assist CalOptima in ensuring **FDRs** and internal departments are in compliance with accreditation, contractual, and regulatory requirements for administering all CalOptima programs including Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), Multipurpose Senior Services Program (MSSP), and any future programs in which CalOptima participates.

5. Establish clearly defined processes and criteria for the evaluation and categorization of internal departments, vendors, and delegated health care providers, as to the entity's qualification as an FDR and conduct such determinations on an ongoing basis.

6. Develop, or revise, reporting for internal departments and **FDRs** including, but not limited to, identifying the scope, frequency and nature of oversight monitoring and auditing, and recommendations related to **Corrective Action Plans (CAPs)**, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan, and present such proposals to the **Compliance Committee** for review and approval.

~~F.~~E. All activities of the **AOC** shall be privileged and not subject to disclosure, with the exception of aggregated reporting results.

~~G.~~F. **AOC** Responsibilities:

FOR 2019 1205 BOD REVIEW

1. Oversight and Reporting

   a. Oversee the readiness assessment processes conducted by Audit & Oversight Department in conjunction with relevant operational departments;

      i. Review and approve findings or readiness assessment to evaluate an ~~FDRs~~**FDR's** ability to perform delegated functions.

   b. Report quarterly findings and recommendations related to Audit & Oversight activities to the **Compliance Committee** for corrective/remedial action;

   c. Conduct focused oversight reviews deemed necessary by the **AOC** to ensure that any deficiencies reported during the oversight of the **FDRs** and/or internal departments have been fully addressed; and

   d. Report and make recommendations to the **Compliance Committee** on a regular, but no less than quarterly basis. All **AOC** recommendations that potentially impact **Members'** access to covered services, or quality of care that requires prompt action, shall be referred immediately to CalOptima's **Compliance Committee**, as appropriate under the circumstances for review and action.

2. Audit & Oversight Work Plan

   a. In accordance with CalOptima Policy HH.4003Δ: Annual Risk Assessment (Internal) and CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate), the Audit & Oversight Department will identify **First Tier Entities (FTEs)** and internal departments that pose the highest compliance risk and develop an annual Audit & Oversight work plan. Based upon a risk assessment that identifies the highest risk **FTEs**, which includes **FTE's** risk assessments, monitoring, and auditing of the **Downstream Entities** with which they contract, and internal departments, an annual Audit & Oversight work plan is created.

   b. ~~Include~~The Audit & Oversight work plan shall include activities identified in other Department Work ~~Plans in the Audit & Oversight Work Plan~~plans.

   c. The annual risk assessments and Audit & Oversight Work Plan shall also be presented to the **Compliance Committee** for review and approval.

3. Audit ~~and~~& Oversight Report

   a. Prepare a report, at least annually, of internal department and **FDR** oversight activities resulting from the Audit & Oversight Work Plan and other relevant ad hoc oversight activities including those related to risk assessments and/or arising from auditing activities (both internal and external).

   b. The report shall include recommendations related to changes and/or addition of oversight activities.

   c. The report shall be presented to the **Compliance Committee** for review and approval.

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4. **AOC** Meetings

   a. The **AOC** shall meet at least monthly and may meet more frequently, as appropriate. The **AOC** ~~chair~~chairs, or ~~any four (4) members~~a quorum of the **AOC**, may call a meeting of the **AOC**. Annually, **AOC members** shall receive a calendar request of meetings for the following calendar year.

   b. ~~The following~~Committee-related information including, but not limited to, the following, shall be distributed to all meeting attendees prior to the **AOC** meeting:

      i. Meeting agenda;

      ii. Final draft of previous **AOC** minutes for approval;

      iii. Listing of open action items; and

      iv. Presentation items.

   ~~c. Minutes~~Activities of the **AOC** ~~meeting shall be confidential.~~

   ~~d.~~c. ~~Ad-hoc AOC meetings may be held at~~, to ~~the discretion of the chairperson, as~~extent not deemed ~~appropriate~~privileged and confidential, shall be disclosable.

IV. ATTACHMENTS

Not Applicable

FOR 20191205BOD REVIEW

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima Health Network Service Agreement
F. CalOptima PACE Program Agreement
G. CalOptima Policy HH.2002Δ: Sanctions
H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate)
J. CalOptima Policy HH.~~4003~~4003Δ: Annual Risk Assessment (Internal)
K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors

~~A. 12/06/18: Regular Meeting of the CalOptima Board of Directors~~
~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors~~
~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors~~

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	09/01/2015	HH.4001	Delegation Oversight Committee	Medi-Cal
Effective	09/01/2015	MA.9127	Delegation Oversight Committee	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9127	Delegation Oversight Committee	OneCare OneCare Connect PACE

FOR 2019 2058OD REVIEW

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Revised	12/07/2017	HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE

FOR 20191205BOD REVIEW

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit and Oversight Committee (AOC)	A subcommittee of the Compliance Committee co-chaired by the ~~Director~~two Directors of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's operational departments.
Compliance Committee	Committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
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 for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FTEs, including the Downstream Entities with which they contract, 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.
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.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity as separately defined herein.

FOR 2019 12/5 BOD REVIEW

Term	Definition
First Tier Entity (FTE)	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a member under a CalOptima program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	An enrollee-beneficiary of a CalOptima program.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

FOR 20191205BOD REVIEW

Policy:	HH.4001Δ
Title:	**Audit & Oversight Committee**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	*Michael Schrader* _____
Effective Date:	09/01/2015
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

FOR 20191205BOD REVIEW

I. PURPOSE

This policy identifies the functions and responsibilities of the **Audit & Oversight Committee (AOC)** responsible for oversight of CalOptima's internal departments and its **First Tier, Downstream, and Related Entities (FDRs)**.

II. POLICY

A. Oversight of delegated and internal operations is critical to CalOptima, this process is mandated by, state and federal laws and regulations, program contracts, and accreditation standards, and is necessary to ensure sound fiscal practices, prevent **Fraud**, **Waste,** and **Abuse**, and the provision of quality health care to CalOptima **Members**.

III. PROCEDURE

A. The Directors of Audit & Oversight shall serve as the chairs of the **Audit & Oversight Committee (AOC)**.

B. Each member of the **AOC** is a voting member. Voting **members** may appoint a **Designee**, when deemed appropriate. The **Designee** may serve as a subject matter expert at the **AOC** meeting; however, the **Designee** will not have voting rights unless approved in advance by the chairs.

C. Establishment of Quorum

1. A quorum for the committee is based on majority. A quorum is required for **AOC** to take action on any agenda item.

2. In the absence of quorum, the meeting may proceed; however, any issues requiring a vote shall be deferred until the next regular meeting, or subject to an electronic vote.

D. CalOptima's **AOC** shall conduct the following activities:

1. Oversee the monitoring, auditing, and reporting processes for internal departments and identified **FDRs** including, but not limited to delegated **Health Networks**;

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2. Provide oversight of internal departments and **FDRs** who perform applicable core administrative functions and/or health care services for any of CalOptima's programs by evaluating performance measures and audit findings;

3. Recommend sanctions upon **FDRs** up to and including the revocation or termination of delegation if the delegated entity's performance is inadequate, in accordance with CalOptima Policy HH.2002Δ: Sanctions;

4. Assist CalOptima in ensuring **FDRs** and internal departments are in compliance with accreditation, contractual, and regulatory requirements for administering all CalOptima programs including Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), Multipurpose Senior Services Program (MSSP), and any future programs in which CalOptima participates.

5. Establish clearly defined processes and criteria for the evaluation and categorization of internal departments, vendors, and delegated health care providers, as to the entity's qualification as an FDR and conduct such determinations on an ongoing basis.

6. Develop, or revise, reporting for internal departments and **FDRs** including, but not limited to, identifying the scope, frequency and nature of oversight monitoring and auditing, and recommendations related to **Corrective Action Plans (CAPs)**, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan, and present such proposals to the **Compliance Committee** for review and approval.

E. All activities of the **AOC** shall be privileged and not subject to disclosure, with the exception of aggregated reporting results.

F. **AOC** Responsibilities:

1. Oversight and Reporting

a. Oversee the readiness assessment processes conducted by Audit & Oversight Department in conjunction with relevant operational departments;

i. Review and approve findings or readiness assessment to evaluate an **FDR's** ability to perform delegated functions.

b. Report quarterly findings and recommendations related to Audit & Oversight activities to the **Compliance Committee** for corrective/remedial action;

c. Conduct focused oversight reviews deemed necessary by the **AOC** to ensure that any deficiencies reported during the oversight of the **FDRs** and/or internal departments have been fully addressed; and

d. Report and make recommendations to the **Compliance Committee** on a regular, but no less than quarterly basis. All **AOC** recommendations that potentially impact **Members'** access to covered services, or quality of care that requires prompt action, shall be referred immediately to CalOptima's **Compliance Committee**, as appropriate under the circumstances for review and action.

2. Audit & Oversight Work Plan

FOR 20191205BOD REVIEW

a. In accordance with CalOptima Policy HH.4003Δ: Annual Risk Assessment (Internal) and CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate), the Audit & Oversight Department will identify **First Tier Entities (FTEs)** and internal departments that pose the highest compliance risk and develop an annual Audit & Oversight work plan. Based upon a risk assessment that identifies the highest risk **FTEs**, which includes **FTE's** risk assessments, monitoring, and auditing of the **Downstream Entities** with which they contract, and internal departments, an annual Audit & Oversight work plan is created.

b. The Audit & Oversight work plan shall include activities identified in other Department Work plans.

c. The annual risk assessments and Audit & Oversight Work Plan shall also be presented to the **Compliance Committee** for review and approval.

3. Audit & Oversight Report

a. Prepare a report, at least annually, of internal department and **FDR** oversight activities resulting from the Audit & Oversight Work Plan and other relevant ad hoc oversight activities including those related to risk assessments and/or arising from auditing activities (both internal and external).

b. The report shall include recommendations related to changes and/or addition of oversight activities.

c. The report shall be presented to the **Compliance Committee** for review and approval.

4. **AOC** Meetings

a. The **AOC** shall meet at least monthly and may meet more frequently, as appropriate. The **AOC** chairs, or a quorum of the **AOC**, may call a meeting of the **AOC**. Annually, **AOC members** shall receive a calendar request of meetings for the following calendar year.

b. Committee-related information including, but not limited to, the following, shall be distributed to all meeting attendees prior to the **AOC** meeting:

i. Meeting agenda;

ii. Final draft of previous **AOC** minutes for approval;

iii. Listing of open action items; and

iv. Presentation items.

c. Activities of the **AOC**, to the extent not deemed privileged and confidential, shall be disclosable.

IV. ATTACHMENTS

Not Applicable

FOR 20191205BOD REVIEW

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima Health Network Service Agreement
F. CalOptima PACE Program Agreement
G. CalOptima Policy HH.2002Δ: Sanctions
H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate)
J. CalOptima Policy HH.4003Δ: Annual Risk Assessment (Internal)
K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2015	HH.4001	Delegation Oversight Committee	Medi-Cal
Effective	09/01/2015	MA.9127	Delegation Oversight Committee	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9127	Delegation Oversight Committee	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised		HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit and Oversight Committee (AOC)	A subcommittee of the Compliance Committee co-chaired by the two Directors of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's operational departments.
Compliance Committee	Committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
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 for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FTEs, including the Downstream Entities with which they contract, 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.
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.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity as separately defined herein.
First Tier Entity (FTE)	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a member under a CalOptima program.

FOR 2019 12/5 BOD REVIEW

Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	An enrollee-beneficiary of a CalOptima program.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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FOR 20191205BOD REVIEW

Policy~~#~~:	HH.4002
Title:	**CalOptima Internal Oversight**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	*Michael Schrader* _____
Effective Date:	12/01/16
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~

~~*Board Approved Policy*~~

I. PURPOSE

This policy defines the process for internal **Monitoring*** and oversight of CalOptima to ensure compliance with statutory, regulatory, contractual, and CalOptima policy requirements.

II. POLICY

A. The Audit & Oversight Department shall establish protocols to ensure compliance risks are identified and conduct effective **Auditing** and **Monitoring** of internal department processes, and outcomes within CalOptima to ensure continuous improvement of **Member** care, administrative processes, and management.

B. The Audit & Oversight Department shall perform an annual risk assessment, as outlined in CalOptima Policy HH.4003: Annual Risk Assessment (Internal), and develop an annual **Internal Audit and Monitoring Work Plan**.

1. The risk assessment and **Internal Audit and Monitoring Work Plan** shall incorporate, at minimum, current Centers for Medicare & Medicaid Services (CMS) and **Department of Health Care Services (DHCS)** contractual and regulatory requirements, **Department of Managed Health Care (DMHC)** Technical Assistance Guides, CMS program audit process and protocols, **National Committee for Quality Assurance (NCQA)** standards, and any identified high-risk areas related to the CalOptima Medi-Cal, OneCare, OneCare Connect, and PACE programs.

C. Every CalOptima department identified on the **Internal Audit and Monitoring Work Plan** (hereinafter, the **Work Plan**) will be subject to **Audit** and/or routine **Monitoring**, and **Focused Reviews.**

D. The **Work Plan** shall identify the functional area(s) subject to **Audit** and describe the schedule of **Audits** to be conducted by the Audit & Oversight Department in the coming year. The **Work Plan** shall also identify specific functional areas that require continuous **Monitoring**.

E. The Audit & Oversight Department shall identify functional areas requiring improvement through internal **Audits** and **Monitoring** activities, risk assessments, or regulatory **Audits**, and shall **Monitor** performance to ensure performance meets applicable regulatory and industry standards. In the event **Monitoring** results reveal deficiencies, the internal department(s) will be subject to a **Focused Review.**

F. CalOptima shall continually assess a functional area's ability to perform functions through initial reviews, on-going **Monitoring**, performance reviews, and analysis of data and reports against industry, regulatory, and/or quality benchmarks, when available.

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G. **Audits** of CalOptima's internal functional areas will be conducted, at minimum, annually by desktop review.

H. CalOptima's Audit & Oversight Department shall maintain documentation of Internal Oversight activities described herein.

I. The **Auditing** and **Monitoring** results shall be reported to the **Audit & Oversight Committee (AOC)**, and the **Compliance Committee** for review and recommendations. When appropriate, CalOptima's Regulatory Affairs & Compliance Department shall inform the CMS, **DHCS**, **DMHC**, National Benefit Integrity Medicare Drug Contractor (NBI MEDIC), or law enforcement of aberrant findings that may cause harm, or impact the delivery of care to CalOptima Members.

J. Failure by an internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policies, or other requirements to CalOptima's Office of Compliance's **Immediate Corrective Action Plan (ICAP)** or **Corrective Action Plan (CAP)** request shall lead to further action, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

III. PROCEDURE

A. CalOptima shall conduct activities in accordance with the terms and conditions of CalOptima regulatory requirements, CalOptima policies and procedures, CalOptima contracts with the CMS and/or the **DHCS**, **DMHC** Full Service Technical Assistance Guides, and **NCQA** Accreditation.

B. CalOptima shall provide Internal Oversight using, without limit, the following components:

1. Desktop reviews;

2. Focused and ad hoc reviews, and **Audits** and **Monitoring**;

3. Periodic reviews and **Audits**;

4. Data Integrity Review;

~~3.~~5. Validation Review; and

~~4.~~6. On-going **monitoring**.

C. Functional areas shall include, without limit:

1. Credentialing, recredentialing, and facility site review;

2. Utilization Management (e.g., program structure, workplan, committee composition, criteria, consistent application of criteria, adherence to established criteria of medical necessity, **Member** and provider notification, rates of admissions and readmissions, emergency room visits, under and over utilization, second opinions, expedited and standard review process, daily census for planned and unplanned admissions, screening **Members** admitted for potential transition of care issues, discharge planning, retrospective review, out-of-network process,

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urgent care services, timeliness, clinical decisions, denial notices, and emergency services, structure~~);~~;);

3. Claims processing/adjudication and payment timeliness;

4. Provider disputes and claim appeals;

5. **Member** rights;

6. Customer service;

7. Exclusion monitoring oversight;

8. Care coordination;

9. Grievance and appeals;

10. Provider network adequacy;

11. Pharmacy;

12. Communication services, including but not limited to, cultural & linguistic services, and alternative formats;

13. Access and availability, including compliance with the Americans with Disabilities Act (ADA);

14. Systems utilized to carry out business functions; and

15. Reporting and **Monitoring**.

D. The Audit & Oversight Department shall develop comprehensive audit tools for Internal Oversight of the focus areas as described in Section III.C. of this Policy, in consultation with subject matter experts including CalOptima operational departments, Regulatory Affairs & Compliance, and Legal Affairs, as necessary. The Audit & Oversight Department shall review and update audit tools in collaboration with the respective subject matter experts annually, or more often, based upon regulatory, contractual, and accreditation changes.

E. Annual Audit Oversight Process

1. At least annually, the Audit & Oversight Department shall identify and schedule an **Audit** as a result of the annual risk assessment, focused **Audit** findings, deficient **Monitoring** results, **Fraud, Waste, and Abuse (FWA)**, or program **Audit** findings. **Internal Oversight Audits** are required annually and shall be conducted as desktop **Audits**.

2. The **Audit** will evaluate, at a minimum, performance with applicable statutes, regulations, and compliance with CalOptima policies and procedures.

3. Two (2) weeks prior to the scheduled **Audit**, the Audit & Oversight Department will send, via email, the CalOptima department management staff a notice confirming the date and scope of the **Audit**. The notice will include a description of any universes required, the **Audit** period, the

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due date, method of delivery, and **Audit** format. The Audit & Oversight Department shall utilize industry standard **Audit** protocols and appropriate methods for **Auditing** with respect to tools, sample size, data mining, etc.

4. Upon receipt of the requested universe(s), the assigned Audit & Oversight auditor shall select a sample size, as determined by Audit & Oversight, that is appropriate for the type of **Audit** being conducted, such as:

   a. Processes considered to be high-risk and/or have potential **Member** harm;

   b. Compliance with CMS, **DHCS**, **DMHC**, and **NCQA**-mandated elements, or contractual obligations; and

   c. Areas identified as deficient in previous **Audits**.

5. If the minimum number of cases is not available in the universe the auditor may elect to expand the **Audit** period or request additional information, or documentation.

6. The Audit & Oversight auditor will notify the CalOptima department of samples selected and documentation required seven (7) calendar days prior to the **Audit** when provided in electronic format, or when sample files are supplied in alternate formats.

   a. The Audit & Oversight auditor shall review sample cases and functional areas shall submit samples and documentation electronically whenever possible.

   b. The Audit & Oversight auditor may, at his or her discretion, request additional materials during the review.

7. The **Audit** will include validation of documentation, including but not limited to CalOptima policies and procedures, training, reports, systems, and file review(s).

8. The Audit & Oversight ~~auditor~~Department shall discuss findings from the annual **Audit** with the respective CalOptima department and document such findings in an **Audit** findings report. If any CalOptima department receives a score of less than the established passing score for an individual **audit** element, the department will be required to develop a **Corrective Action Plan** in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

   a. The Audit & Oversight ~~auditor~~Department shall have ultimate responsibility for remediation, monitoring, and reporting of the **CAP** to the **AOC**. The Audit & Oversight ~~auditor~~Department shall report the findings of the audit, **CAPs**, if any, and the timeline for **CAP** remediation to the **AOC**.

9. **Audit** findings will be presented to the **AOC** by the Audit & Oversight Department for the respective functional area reviewed. The Audit & Oversight Department shall determine any follow up activities, process improvement, and/or additional review based on the recommendations of the Audit & Oversight auditor.

10. A department must resolve the elements of the **CAP** in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

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11. In the event the elements of the **CAP** are not successfully completed ~~within ninety (90) calendar days~~in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan, the Director of Audit & Oversight shall report the **CAP** status to the **AOC** following the **CAP** period. ~~The AOC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended.~~

    a. The Audit & Oversight Department must demonstrate to the **AOC** the appropriateness for an extension and provide a detailed action plan to ensure that the items for correction are being addressed in a timely manner.

12. The Audit & Oversight Department shall determine whether ad hoc **audits**, reviews, and or other remediation or actions are necessary to resolve identified issues. Issues escalated will be reviewed by the Audit & Oversight Department, **AOC**, and the **Compliance Committee**, as applicable.

F. Ongoing Internal Oversight Process

1. The Audit & Oversight Department will conduct on-going Internal Oversight of the business areas outlined in Section III.C. of this policy based on the risk level determined during the annual risk assessment, and as outlined on the **Internal Audit and Monitoring Work Plan**.

2. Internal Dashboard Reporting: On a monthly basis, data shall be used to **Monitor** areas for processing timeliness and accuracy of business activities.

    a. The **AOC** shall Monitor dashboard results and may make recommendations for corrective action if performance falls below the standard defined by the **AOC**.

    b. If there is a consistent pattern of non-compliance, the Audit & Oversight Department shall conduct a **Focused Review.**

        i. If the results of the **Focused Review** are unfavorable, the auditor will escalate for further action. This includes, but is not limited to, reporting the issue up to **Compliance Committee** for disciplinary action and/or development of remediation plan.

G. **Corrective Action Plan**

1. If any area of deficiency or non-compliance is identified, including but not limited to, **Member** or **Provider Complaints**, readiness assessment reviews, regular reports, oversight reviews, and ongoing **Monitoring**, the Audit & Oversight Department will be required to issue a **CAP** request, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

~~IV. ATTACHMENTS~~
IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan

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B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2005Δ: Corrective Action Plan
F. CalOptima Policy HH.4003: Annual Risk Assessment
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Title 42, Code of Federal Regulations (C.F.R.), §455.2
I. Welfare and Institutions Code, §14043.1(a)

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

None to Date

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

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	12/01/2016	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/07/2017	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/06/2018	HH.4002	CalOptima Internal Oversight	Administrative
Revised		HH.4002	CalOptima Internal Oversight	Administrative

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee (AOC)	CalOptima's Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is responsible for overseeing the delegated and internal activities of CalOptima.
Business Owner	CalOptima management and staff vested in the compliance of their respective CalOptima functional area in accordance with statutory, regulatory, contractual, and CalOptima policy requirements.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
Focused Review	An audit that specifically targets areas of potential deficiency.

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Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Immediate Corrective Action Plan (ICAP)	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Internal Oversight	The process by which CalOptima's Audit and Oversight Department conducts audits to monitor internal functional areas in accordance with regulatory, statutory, contractual, and CalOptima policy requirements to ensure health plan compliance.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.4002
Title:	**CalOptima Internal Oversight**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	*Michael Schrader* _____
Effective Date:	12/01/16
Revised Date:	

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I. PURPOSE

This policy defines the process for internal **Monitoring*** and oversight of CalOptima to ensure compliance with statutory, regulatory, contractual, and CalOptima policy requirements.

II. POLICY

A. The Audit & Oversight Department shall establish protocols to ensure compliance risks are identified and conduct effective **Auditing** and **Monitoring** of internal department processes, and outcomes within CalOptima to ensure continuous improvement of **Member** care, administrative processes, and management.

B. The Audit & Oversight Department shall perform an annual risk assessment, as outlined in CalOptima Policy HH.4003: Annual Risk Assessment (Internal), and develop an annual **Internal Audit and Monitoring Work Plan**.

1. The risk assessment and **Internal Audit and Monitoring Work Plan** shall incorporate, at minimum, current Centers for Medicare & Medicaid Services (CMS) and **Department of Health Care Services (DHCS)** contractual and regulatory requirements, **Department of Managed Health Care (DMHC)** Technical Assistance Guides, CMS program audit process and protocols, **National Committee for Quality Assurance (NCQA)** standards, and any identified high-risk areas related to the CalOptima Medi-Cal, OneCare, OneCare Connect, and PACE programs.

C. Every CalOptima department identified on the **Internal Audit and Monitoring Work Plan** (hereinafter, the **Work Plan**) will be subject to **Audit** and/or routine **Monitoring**, and **Focused Reviews.**

D. The **Work Plan** shall identify the functional area(s) subject to **Audit** and describe the schedule of **Audits** to be conducted by the Audit & Oversight Department in the coming year. The **Work Plan** shall also identify specific functional areas that require continuous **Monitoring**.

E. The Audit & Oversight Department shall identify functional areas requiring improvement through internal **Audits** and **Monitoring** activities, risk assessments, or regulatory **Audits**, and shall **Monitor** performance to ensure performance meets applicable regulatory and industry standards. In the event **Monitoring** results reveal deficiencies, the internal department(s) will be subject to a **Focused Review.**

F. CalOptima shall continually assess a functional area's ability to perform functions through initial reviews, on-going **Monitoring**, performance reviews, and analysis of data and reports against industry, regulatory, and/or quality benchmarks, when available.

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

G. **Audits** of CalOptima's internal functional areas will be conducted, at minimum, annually by desktop review.

H. CalOptima's Audit & Oversight Department shall maintain documentation of Internal Oversight activities described herein.

I. The **Auditing** and **Monitoring** results shall be reported to the **Audit & Oversight Committee (AOC)**, and the **Compliance Committee** for review and recommendations. When appropriate, CalOptima's Regulatory Affairs & Compliance Department shall inform the CMS, **DHCS**, **DMHC**, National Benefit Integrity Medicare Drug Contractor (NBI MEDIC), or law enforcement of aberrant findings that may cause harm, or impact the delivery of care to CalOptima Members.

J. Failure by an internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policies, or other requirements to CalOptima's Office of Compliance's **Immediate Corrective Action Plan (ICAP)** or **Corrective Action Plan (CAP)** request shall lead to further action, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

III. PROCEDURE

A. CalOptima shall conduct activities in accordance with the terms and conditions of CalOptima regulatory requirements, CalOptima policies and procedures, CalOptima contracts with the CMS and/or the **DHCS**, **DMHC** Full Service Technical Assistance Guides, and **NCQA** Accreditation.

B. CalOptima shall provide Internal Oversight using, without limit, the following components:

1. Desktop reviews;

2. Focused and ad hoc reviews, and **Audits** and **Monitoring**;

3. Periodic reviews and **Audits**;

4. Data Integrity Review;

5. Validation Review; and

6. On-going **monitoring**.

C. Functional areas shall include, without limit:

1. Credentialing, recredentialing, and facility site review;

2. Utilization Management (e.g., program structure, workplan, committee composition, criteria, consistent application of criteria, adherence to established criteria of medical necessity, **Member** and provider notification, rates of admissions and readmissions, emergency room visits, under and over utilization, second opinions, expedited and standard review process, daily census for planned and unplanned admissions, screening **Members** admitted for potential transition of care issues, discharge planning, retrospective review, out-of-network process, urgent care services, timeliness, clinical decisions, denial notices, and emergency services, structure);

3. Claims processing/adjudication and payment timeliness;

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4. Provider disputes and claim appeals;

5. **Member** rights;

6. Customer service;

7. Exclusion monitoring oversight;

8. Care coordination;

9. Grievance and appeals;

10. Provider network adequacy;

11. Pharmacy;

12. Communication services, including but not limited to, cultural & linguistic services, and alternative formats;

13. Access and availability, including compliance with the Americans with Disabilities Act (ADA);

14. Systems utilized to carry out business functions; and

15. Reporting and **Monitoring**.

D. The Audit & Oversight Department shall develop comprehensive audit tools for Internal Oversight of the focus areas as described in Section III.C. of this Policy, in consultation with subject matter experts including CalOptima operational departments, Regulatory Affairs & Compliance, and Legal Affairs, as necessary. The Audit & Oversight Department shall review and update audit tools in collaboration with the respective subject matter experts annually, or more often, based upon regulatory, contractual, and accreditation changes.

E. Annual Audit Oversight Process

1. At least annually, the Audit & Oversight Department shall identify and schedule an **Audit** as a result of the annual risk assessment, focused **Audit** findings, deficient **Monitoring** results, **Fraud, Waste, and Abuse (FWA)**, or program **Audit** findings. **Internal Oversight Audits** are required annually and shall be conducted as desktop **Audits**.

2. The **Audit** will evaluate, at a minimum, performance with applicable statutes, regulations, and compliance with CalOptima policies and procedures.

3. Two (2) weeks prior to the scheduled **Audit**, the Audit & Oversight Department will send, via email, the CalOptima department management staff a notice confirming the date and scope of the **Audit**. The notice will include a description of any universes required, the **Audit** period, the due date, method of delivery, and **Audit** format. The Audit & Oversight Department shall utilize industry standard **Audit** protocols and appropriate methods for **Auditing** with respect to tools, sample size, data mining, etc.

4. Upon receipt of the requested universe(s), the assigned Audit & Oversight auditor shall select a sample size, as determined by Audit & Oversight, that is appropriate for the type of **Audit** being conducted, such as:

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a. Processes considered to be high-risk and/or have potential **Member** harm;

b. Compliance with CMS, **DHCS**, **DMHC**, and **NCQA**-mandated elements, or contractual obligations; and

c. Areas identified as deficient in previous **Audits**.

5. If the minimum number of cases is not available in the universe the auditor may elect to expand the **Audit** period or request additional information, or documentation.

6. The Audit & Oversight auditor will notify the CalOptima department of samples selected and documentation required seven (7) calendar days prior to the **Audit** when provided in electronic format, or when sample files are supplied in alternate formats.

   a. The Audit & Oversight auditor shall review sample cases and functional areas shall submit samples and documentation electronically whenever possible.

   b. The Audit & Oversight auditor may, at his or her discretion, request additional materials during the review.

7. The **Audit** will include validation of documentation, including but not limited to CalOptima policies and procedures, training, reports, systems, and file review(s).

8. The Audit & Oversight Department shall discuss findings from the annual **Audit** with the respective CalOptima department and document such findings in an **Audit** findings report. If any CalOptima department receives a score of less than the established passing score for an individual **audit** element, the department will be required to develop a **Corrective Action Plan** in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

   a. The Audit & Oversight Department shall have ultimate responsibility for remediation, monitoring, and reporting of the **CAP** to the **AOC**. The Audit & Oversight Department shall report the findings of the audit, **CAPs**, if any, and the timeline for **CAP** remediation to the **AOC**.

9. **Audit** findings will be presented to the **AOC** by the Audit & Oversight Department for the respective functional area reviewed. The Audit & Oversight Department shall determine any follow up activities, process improvement, and/or additional review based on the recommendations of the Audit & Oversight auditor.

10. A department must resolve the elements of the **CAP** in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

11. In the event the elements of the **CAP** are not successfully completed in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan, the Director of Audit & Oversight shall report the **CAP** status to the **AOC** following the **CAP** period.

    a. The Audit & Oversight Department must demonstrate to the **AOC** the appropriateness for an extension and provide a detailed action plan to ensure that the items for correction are being addressed in a timely manner.

12. The Audit & Oversight Department shall determine whether ad hoc **audits**, reviews, and or other remediation or actions are necessary to resolve identified issues. Issues escalated will be

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reviewed by the Audit & Oversight Department, **AOC**, and the **Compliance Committee**, as applicable.

F. Ongoing Internal Oversight Process

1. The Audit & Oversight Department will conduct on-going Internal Oversight of the business areas outlined in Section III.C. of this policy based on the risk level determined during the annual risk assessment, and as outlined on the **Internal Audit and Monitoring Work Plan**.

2. Internal Dashboard Reporting: On a monthly basis, data shall be used to **Monitor** areas for processing timeliness and accuracy of business activities.

   a. The **AOC** shall Monitor dashboard results and may make recommendations for corrective action if performance falls below the standard defined by the **AOC**.

   b. If there is a consistent pattern of non-compliance, the Audit & Oversight Department shall conduct a **Focused Review.**

      i. If the results of the **Focused Review** are unfavorable, the auditor will escalate for further action. This includes, but is not limited to, reporting the issue up to **Compliance Committee** for disciplinary action and/or development of remediation plan.

G. **Corrective Action Plan**

1. If any area of deficiency or non-compliance is identified, including but not limited to, **Member** or **Provider Complaints**, readiness assessment reviews, regular reports, oversight reviews, and ongoing **Monitoring**, the Audit & Oversight Department will be required to issue a **CAP** request, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2005Δ: Corrective Action Plan
F. CalOptima Policy HH.4003: Annual Risk Assessment
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Title 42, Code of Federal Regulations (C.F.R.), §455.2
I. Welfare and Institutions Code, §14043.1(a)

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VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/07/2017	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/06/2018	HH.4002	CalOptima Internal Oversight	Administrative
Revised		HH.4002	CalOptima Internal Oversight	Administrative

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee (AOC)	CalOptima's Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is responsible for overseeing the delegated and internal activities of CalOptima.
Business Owner	CalOptima management and staff vested in the compliance of their respective CalOptima functional area in accordance with statutory, regulatory, contractual, and CalOptima policy requirements.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
Focused Review	An audit that specifically targets areas of potential deficiency.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)

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Term	Definition
Immediate Corrective Action Plan (ICAP)	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Internal Oversight	The process by which CalOptima's Audit and Oversight Department conducts audits to monitor internal functional areas in accordance with regulatory, statutory, contractual, and CalOptima policy requirements to ensure health plan compliance.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy ~~#:~~:	HH.1105Δ
Title:	**Fraud, Waste, and Abuse Detection**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*Michael Schrader* _____
Effective Date:	06/01/~~99~~1999
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy establishes a process to detect~~, correct, and prevent~~ suspected **Fraud**, **Waste**, or **Abuse** **(FWA)** in a CalOptima program by a **Member**, **Provider** or **Prescribing Provider**, **Practitioner**, a CalOptima **Employee**, **First Tier, Downstream, and Related Entities (FDRs)**, Billing Intermediary, and CalOptima's **Health Networks**, in accordance with federal and state regulations.

II. POLICY

A. CalOptima maintains a zero-tolerance policy toward **Fraud**, **Waste**, and **Abuse**.

B. CalOptima shall follow the process for detecting suspected **Fraud**, **Waste**, or **Abuse**, outlined in this policy.

C. CalOptima and its **First Tier, Downstream, and Related Entities (FDRs)** shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of **Covered Services**, which include but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, **Health Insurance Portability and Accountability Act (HIPAA)**, and other applicable statutes.

D. CalOptima's Pharmacy Management Department shall identify **Fraud** and **Abuse** of controlled substances by **Members**, **Prescribing Providers**, and **Pharmacies** dispensing drugs to **Members**, by conducting drug claim reviews and monitoring utilization safety standards, to detect opioid related misuse, and refer cases to the Office of Compliance in accordance with CalOptima Policy GG.1423: Medication Quality Assurance Program.

~~D.~~E. CalOptima's Office of Compliance shall investigate, and report suspected **Fraud**, **Waste**, or **Abuse**, in accordance with CalOptima Policy HH.1107Δ: **Fraud**, **Waste**, and **Abuse** Investigation and Reporting.

~~E.~~F. CalOptima shall provide regular training and information sessions to its **Employees** and **FDRs** regarding **Fraud**, **Waste**, and **Abuse**, and shall inform **Members** regarding **Fraud**, **Waste**, and **Abuse** and the provisions of this policy.

~~F.~~G. CalOptima **Employees** and **FDRs** are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima program.

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* Terms in **bold** are included in the Glossary.
Back to Agenda

CalOptima maintains a strict policy of non-retaliation and non-retribution toward ~~employees and its FDRs who make such reports in good faith. CalOptima Employees and its FDRs are protected from retaliation under Title 31, United States Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections.~~**Employees** and its **FDRs** who make such reports in good faith. CalOptima shall treat the detection of suspected **FWA** in a confidential manner to the extent possible.

~~G. CalOptima shall review this Policy on at least an annual basis to ensure relevancy and accuracy, ensuring that CalOptima's FWA program is in alignment with industry best practices.~~

III. PROCEDURE

A. CalOptima may detect **Fraud**, **Waste**, or **Abuse** by a **Member** in circumstances that include, but are not limited to, the following:

~~1. Using another individual's identity, Benefits Identification Card (BIC), CalOptima or Health Network identification (ID) card, Medi-Cal or Medicare number, or other documentation of Medi-Cal, Medicare, or CalOptima program eligibility to obtain Covered Services, unless such person is an Authorized Representative who is presenting such document, or information, on behalf of a Member to obtain Covered Services for that Member;~~

~~2. Selling, loaning, or giving a Member's identity, Benefits Identification Card (BIC), Health Network identification (ID) card, Medi-Cal or Medicare number, or other documentation of Medi-Cal, Medicare or CalOptima program eligibility to obtain Covered Services, unless such person is an Authorized Representative who is obtaining services on behalf of a Member;~~

~~3. Making an unsubstantiated declaration of Medi-Cal or Medicare eligibility;~~

~~4. Using a Covered Service for purposes other than the purposes for which it was prescribed or provided, including use of such Covered Service by an individual other than the Member for whom the Covered Service was prescribed or provided;~~

~~5. Failing to report Other Health Coverage (OHC); and~~

~~6. Soliciting or receiving a kickback, bribe, rebate, or other financial incentive as an inducement to receive or not receive Covered Services.~~

B. MEMBER FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain **Covered Services**	**Members** with multiple areas of service; **Members** who attempt more than one PCP; reports of **Members** who are hiding assets or income
M02	Selling, loaning, or giving a **Member's** identity or documentation of Medi-Cal eligibility to obtain services	**Members** with multiple areas of service; **Members** who attempt more than one PCP; reports of **Members** who are hiding assets or income
M03	Making an unsubstantiated declaration of eligibility	**Members** with multiple areas of service; **Members** who attempt more than one PCP; reports of **Members** who are hiding assets or income

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B. MEMBER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M04	Using a **Covered Service** for purposes other than the purpose for which it was prescribed, or using a **Covered Service** inappropriately	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive **Covered Services**.	Hotline reports; internal reports; reports by **Health Networks**
M07	Other (please specify)	Any source
M08	**Member Pharmacy** Utilization	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
M09	Doctor Shopping	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
M10	Altered Prescription	**Provider** report; DEA report; **Pharmacy** report; **PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software

B. CalOptima may detect **Fraud**, **Waste**, or **Abuse** by an **FDR** in circumstances that include, but are not limited to, the following:

~~1. Unsubstantiated declaration of eligibility to participate in the Medi-Cal, OneCare, OneCare Connect, or Program of All-Inclusive Care for the Elderly (PACE) program as a Provider, Practitioner, Billing Intermediary, or Health Network;~~

~~2. Submission of a claim or a request for payment for:~~

~~a. Covered Services that are substantially and demonstrably in excess of an individual's usual charges for such Covered Services;~~

~~b. Covered Services that were not provided to the Member for whom such Covered Services were claimed;~~

~~c. Covered Services substantially in excess of the quantity that is Medically Necessary for the Member;~~

~~d. Covered Services using a billing code that will result in greater payment than the billing code that reflects the Covered Services actually provided;~~

~~e. Covered Services that were already included in the capitation rate; and~~

~~f. Covered Services billed to both CalOptima and another third-party payer without making full disclosure of material facts or notification of other insurance payments.~~

~~3. Charging a Member in excess of allowable co-payments or deductibles for Covered Services;~~

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~~4. Billing a Member for Covered Services without obtaining written consent to bill for such Covered Services;~~

~~5. Soliciting, offering, receiving, or paying a kickback, bribe, or rebate as an inducement to refer or fail to refer a Member;~~

~~6. Failing to disclose any significant beneficial interest in any other Provider to which the Provider or Practitioner may refer a Member for the provision of Covered Services;~~

~~7. Billing intermediary failure to register with the California Department of Health Care Services (DHCS), as appropriate;~~

~~8. False certification of Medical Necessity;~~

~~9. Attributing a diagnosis code to a Member that does not accurately reflect the Member's Medical Condition for the purposes of obtaining higher reimbursement;~~

~~10. Providing false, or inaccurate, Credentialing information;~~

~~11. Providing false, or inaccurate, information during the CalOptima Provider registration process; and~~

~~12. Submitting data files or reports that contain:~~

~~a. Unsubstantiated data;~~

~~b. Data that is inconsistent with underlying clinical, Encounter, or payment records; or~~

~~c. Data that has been altered in a manner, or for a purpose, that is inconsistent with CalOptima policies, contract, or applicable regulations and statutes.~~

FDR FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program	**Provider** information not able to be verified during credentialing or contracting process; **Providers** on the excluded **Provider** list
P02	Submission of claims for **Covered Services** that are substantially and demonstrably in excess of any individual's usual charges for such **Covered Services**	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
P03	Submission of claims for **Covered Services** that are not actually provided to the **Member** for which the claim is submitted	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software; verification survey; hotline
P04	Submission of claims for **Covered Services** that are in excess of the quantity that is **Medically Necessary**	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software

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FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P05	Submission of claims for **Covered Services** that are that are billed using a code that would result in greater payment than the code that reflects the **Covered Services**	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
P06	Submission of claims for **Covered Services** that is already included in the capitation rate	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
P07	Submission of claims for **Covered Services** that are submitted for payment to both CalOptima and another third-party payer without full disclosure	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software; payment by OHI
P08	Charging a **Member** in excess of allowable co-payments and deductibles for **Covered Services**	**Member** report; hotline report; oversight audits
P09	Billing a **Member** for **Covered Services** without obtaining written consent to bill for such service	**Member** report; hotline report; oversight audits
P10	Failure to disclose conflict of interest	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a **Member**	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Care Services	Oversight audit; report by regulatory body; hotline
P13	False certification of **Medical Necessity**	**Medical Record** review; claims data; **Encounter** data; **FWA** software
P14	Attributing a diagnosis code to a **Member** that does not reflect the **Member's** medical condition for the purpose of obtaining higher reimbursement	**Medical Record** review; claims data; **Encounter** data; **FWA** software
P15	False or inaccurate Minimum Standards or credentialing information	Hotline; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with clinical, **Encounter** or payment records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations	**Medical Record** review; claims data; **Encounter** data; **FWA** software

C. CalOptima may detect **Fraud**, **Waste**, or **Abuse** by an **Employee** in circumstances that include, but are not limited to, the following:

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EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a **Member's** identity or documentation of Medi-Cal eligibility to obtain services	Hotline report; Data analytics; Referrals to SIU
E02	Use of a **Member's** identity or documentation of Medi-Cal eligibility to obtain a gain	Hotline report, referrals to SIU
E03	**Employee** assistance to **Providers** with the submission of false claims for **Covered Services** that are not actually provided to the **Member** for which the claim is submitted	Hotline report; Referrals to SIU
E04	**Employee** deceptively accessing company confidential information for purpose of a gain	Hotline report; Data analytics; Referrals to SIU

C. Training

1. CalOptima's Office of Compliance shall provide regular training and education to **Employees** and **FDRs** regarding the process for detecting suspected **FWA**, the specific provisions regarding **FWA** under the False Claims Act, and the protections afforded to those who report such concerns in good faith and in accordance with CalOptima Policy HH.5004Δ: False Claims Act Education.

2. CalOptima shall provide regular **FWA** training and information sessions to:

   a. New **Employees**, upon hire;

   b. CalOptima **Employees**, on an annual basis; and

   c. **Health Networks**, on an annual basis.

3. CalOptima shall provide **Members** with information related to **FWA** through:

   a. The **Member** Handbook;

   b. Periodic communications; and

   c. The CalOptima website.

D. Detection

1. CalOptima may receive ~~complaints~~**Complaints** of suspected **FWA** from sources, including but not limited to:

   a. CalOptima's Compliance and Ethics Hotline;

   b. Claims data history:

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c. **Encounter** data;

d. **Medical Records** audits;

e. **Member** and **Provider** ~~complaints~~**Complaints**, appeals, and grievance reviews;

f. Utilization Management reports;

g. **Provider** utilization profiles;

h. **Pharmacy** data;

i. Monitoring and auditing activities;

j. Monitoring external health care **FWA** cases and determining if CalOptima's **FWA** Program can be strengthened with information gleaned from the case activity; and/or

k. Internal and external surveys, reviews, and audits.

2. The Office of Compliance shall provide oversight to the **Health Networks'** Compliance Programs to ensure that the programs are in place, are comprehensive, and in compliance with CalOptima contractual requirements.

3. CalOptima shall utilize "claims edits" in accordance with federal and state regulations, the **DHCS** Contract, and industry best practices, including but not limited to the National Correct Coding Initiative (NCCI).

4. CalOptima shall conduct data validation reviews by claims auditors within the Office of Compliance. These reviews are intended to detect any anomalies between items billed, items rendered, **Medical Records**, and all affiliated documentation related to the claims and **Encounters**.

5. CalOptima shall utilize data analytics including software to identify potential **FWA** cases. This data compares CalOptima claims and **Encounters** against national data to identify any suspected instances of **FWA**. These cases are forwarded to the Special Investigations Unit (SIU) for investigation.

6. CalOptima shall perform reviews on data samples to test for potential **FWA** through methods, including, but not limited to:

~~a. Ensuring that documentation of Prior Authorization(s) is on file for services or medications requiring Prior Authorization;~~

~~b.~~a. Reviewing ~~low-dollar/high-volume~~ utilization by doctor, specialty, and geographic comparison;

~~c. CalOptima shall conduct monthly reviews of claims to review for adjustment codes and denials, reviewing for inappropriate denials and improper coding, with a focus on Current Procedural Terminology (CPT) codes 99284 and 99285. CalOptima's Claims Auditors shall review claims for emergency services to ensure that coding does not occur when claims are submitted without accompanying Medical Records. Emergency room claims are reviewed~~

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~~during regular claims audits, and documentation is requested from the Health Network, at the time of the audit. Results of the audit are reviewed by the Audit and Oversight Committee (AOC). The AOC is responsible for issuing corrective actions for Health Networks whose Providers are found to be coding inappropriately;~~

~~d. CalOptima reviews Provider claims that are identified as potential FWA. Claims may be identified by the claims review software system, by the claims auditors, by internal and external claims and compliance audits, or any other source that identifies potential FWA. As part of the review process, CalOptima documents the investigation of the claims or Provider in the FWA Tracking Database. Once the investigation is completed, CalOptima shall report FWA as applicable and in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste, Abuse Investigation and Reporting.~~

~~e.~~b. ~~In accordance with the Pharmacist Referral to SIU Team Desktop,~~ CalOptima's **Pharmacy** Department shall refer cases to the SIU Team for **Members** exhibiting drug seeking behavior or suspected of **FWA** issues related to **Pharmacy** services.

7. CalOptima shall implement a Service Verification Survey process to survey a sampling of **Members** ~~monthly~~as needed. The Service Verification process may be used to ensure that:

   a. **Covered Services** that were billed were received;

   b. Face-to-face services were provided for services/equipment/medications requiring recent or regular face-to-face appointments;

   c. **Durable Medical Equipment (DME)** that were billed were received; and

   d. Medications that were billed were received.

   e. The focus of these surveys will vary as decided by the SIU and/or the Office of Compliance designated staff. The focus may be on a specific code, **Provider**, **Member** category, geographic area, and **DME** description, reports by other agencies of potential **FWA**, and industry findings and best practices.

E. Upon detection of suspected **Fraud**, **Waste**, and/or **Abuse**, the Office of Compliance shall review the suspected activity ~~using data from reports, including but not limited to, the following:~~in accordance with CalOptima Policy HH.1107: **Fraud**, **Waste**, and **Abuse** Investigation and Reporting.

~~1. Claims data;~~

~~2. Encounter data;~~

~~3. Medical Records;~~

~~4. Member and Provider complaints, appeals, and grievance reviews;~~

~~5. Utilization Management reports;~~

~~6. Pharmacy data;~~

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~~7. Audits;~~

~~8. Provider utilization profiles;~~

~~9. Member utilization profiles;~~

~~10. Geographic and demographic studies;~~

~~11. Evaluation of a Provider's Member capacity; and~~

~~12. Interviews.~~

~~F. A CalOptima Employee who detects suspected Fraud, Waste, or Abuse may complete a Suspected Fraud or Abuse Referral Form or otherwise report suspected FWA in accordance with Section III.H. of this Policy.~~

~~G. An FDR with a contractual obligation to report suspected Fraud, Waste, or Abuse shall notify CalOptima of suspected Fraud, Waste, or Abuse, in accordance with the terms and conditions of its contract and this policy.~~

~~H. CalOptima shall provide a method for CalOptima Employees, FDRs, and Members to anonymously report suspected Fraud, Waste, or Abuse to the Office of Compliance. CalOptima Employees, FDRs, and Members may call the Compliance and Ethics Hotline at (877) 837-4417 to anonymously report concerns regarding Fraud, Waste, and Abuse.~~

~~I. CalOptima departments and its FDRs shall track, trend, and analyze data for suspected Fraud, Waste, or Abuse, and report such suspected Fraud, Waste or Abuse to CalOptima's Office of Compliance.~~

F. CalOptima shall treat the detection of suspected **Fraud**, **Waste**, or **Abuse** in a confidential manner, and shall not retaliate or make retribution against any CalOptima **Employee**, **FDR**, or **Member** for such detection, in accordance with CalOptima policy HH.3012Δ: Non-Retaliation for Reporting Violations.

IV. ATTACHMENTS

A. Suspected Fraud or Abuse Referral Form (English)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services for Medi-Cal
~~A. California Business and Professions Code, §4040~~
~~B. California Government Code 12650, California False Claims Act~~
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Service (DHCS) for Cal MediConnect
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~D.A. CalOptima Contract with Department of Health Care Services for Medi-Cal~~
D. CalOptima PACE Program Agreement
E. CalOptima Contract for Health Care Services
~~F.A. CalOptima PACE Program Agreement~~

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~~G.~~F. CalOptima Policy HH.1107Δ: Fraud, Waste and Abuse Investigation and Reporting
~~H.~~G. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
~~I.~~H. CalOptima Policy HH.5004Δ: False Claims Act Education
I. CalOptima Policy GG.1423: Medication Quality Assurance Program
J. Department of Health Care Services All Plan Letter (APL) 19-012: Federal Drugs Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse
~~J.~~A. California Government Code 12650, California False Claims Act ~~CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Service (DHCS) for Cal MediConnect~~
K. Title 31, United States Code (U.S.C.), §3730(h)
L. Title 42, Code of Federal Regulations (C.F.R.), §455.2
M. Welfare and Institutions Code, §§14026 and 14107.2
N. Welfare and Institutions Code, §14043.1(a)

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

None to Date

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

~~A. 12/06/18: Regular Meeting of the CalOptima Board of Directors~~
~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors~~
~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors~~

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~~REVIEW/~~

~~VIII.~~I. ~~REVISION HISTORY~~

Date	Meeting
~~Version~~12/06/2018	Regular Meeting of the CalOptima Board of Directors~~Line(s) of Business~~
~~Effective~~12/07/2017	Regular Meeting of the CalOptima Board of Directors~~06/1999~~
~~Revised~~ 12/01/2016	Regular Meeting of the CalOptima Board of Directors~~08/2000~~

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1999	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	08/01/2000	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2004	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	01/01/2007	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Effective	01/01/2007	MA.9107	Fraud, Waste, and Abuse Detection	OneCare
Revised	02/01/2013	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare
Revised	04/01/2014	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	04/01/2014	MA.9107	Fraud, Waste, and Abuse Detection	OneCare
Revised	12/01/2014	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	09/01/2015	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2015	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	06/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	06/01/2016	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the ~~provider~~Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from ~~fraud~~Fraud, because the distinction between "~~fraud~~Fraud" and "~~abuse~~Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
~~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 un-emancipated minors.~~
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.

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Term	Definition
Covered Service	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, 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. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). PACE: Items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132, except those services specifically excluded under the CalOptima PACE Program Agreement, Exhibit E, Attachment 1, Section 26.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate ~~provider~~Provider of both health and administrative services.
Durable Medical Equipment (DME)	Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Employee	Any and all ~~employees~~Employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary ~~employees~~Employees and volunteers.

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Term	Definition
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~~Provider, including out-of-network services and sub-capitated and delegated Covered Services.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted ~~providers~~Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or ~~fraudulent~~Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Network	The contracted ~~health networks~~Health Networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
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
Member	A beneficiary who is enrolled in a CalOptima Program.
Other Health Coverage (OHC)	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.
Personal 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 un-emancipated minors.

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Term	Definition
Pharmacy	An area, place or premises licensed by the State Board of Pharmacy in which the profession of ~~pharmacy~~Pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
Pharmacy Benefit Manager (PBM)	An entity that provides ~~pharmacy~~Pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and ~~prior authorization~~Prior Authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Practitioner	A licensed independent ~~practitioner~~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.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist, or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures
Provider	A physician, nurse, nurse mid-wife, nurse ~~practitioner~~Practitioner, medical technician, physician assistant, hospital, laboratory, ancillary ~~provider~~Provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.1105Δ
Title:	**Fraud, Waste, and Abuse Detection**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*Michael Schrader* _____
Effective Date:	06/01/1999
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

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I. PURPOSE

This policy establishes a process to detect suspected **Fraud**, **Waste**, or **Abuse (FWA)** in a CalOptima program by a **Member**, **Provider** or **Prescribing Provider**, **Practitioner**, a CalOptima **Employee**, **First Tier, Downstream, and Related Entities (FDRs)**, Billing Intermediary, and CalOptima's **Health Networks**, in accordance with federal and state regulations.

II. POLICY

A. CalOptima maintains a zero-tolerance policy toward **Fraud**, **Waste**, and **Abuse**.

B. CalOptima shall follow the process for detecting suspected **Fraud**, **Waste**, or **Abuse**, outlined in this policy.

C. CalOptima and its **First Tier, Downstream, and Related Entities (FDRs)** shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of **Covered Services**, which include but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, **Health Insurance Portability and Accountability Act (HIPAA)**, and other applicable statutes.

D. CalOptima's Pharmacy Management Department shall identify **Fraud** and **Abuse** of controlled substances by **Members**, **Prescribing Providers**, and **Pharmacies** dispensing drugs to **Members**, by conducting drug claim reviews and monitoring utilization safety standards, to detect opioid related misuse, and refer cases to the Office of Compliance in accordance with CalOptima Policy GG.1423: Medication Quality Assurance Program.

E. CalOptima's Office of Compliance shall investigate, and report suspected **Fraud**, **Waste**, or **Abuse**, in accordance with CalOptima Policy HH.1107Δ: **Fraud**, **Waste**, and **Abuse** Investigation and Reporting.

F. CalOptima shall provide regular training and information sessions to its **Employees** and **FDRs** regarding **Fraud**, **Waste**, and **Abuse**, and shall inform **Members** regarding **Fraud**, **Waste**, and **Abuse** and the provisions of this policy.

G. CalOptima **Employees** and **FDRs** are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima program. CalOptima

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

maintains a strict policy of non-retaliation and non-retribution toward **Employees** and its **FDRs** who make such reports in good faith. CalOptima shall treat the detection of suspected **FWA** in a confidential manner to the extent possible.

III. PROCEDURE

A. CalOptima may detect **Fraud**, **Waste**, or **Abuse** by a **Member** in circumstances that include, but are not limited to, the following:

B. MEMBER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain **Covered Services**	**Members** with multiple areas of service; **Members** who attempt more than one PCP; reports of **Members** who are hiding assets or income
M02	Selling, loaning, or giving a **Member's** identity or documentation of Medi-Cal eligibility to obtain services	**Members** with multiple areas of service; **Members** who attempt more than one PCP; reports of **Members** who are hiding assets or income
M03	Making an unsubstantiated declaration of eligibility	**Members** with multiple areas of service; **Members** who attempt more than one PCP; reports of **Members** who are hiding assets or income
M04	Using a **Covered Service** for purposes other than the purpose for which it was prescribed, or using a **Covered Service** inappropriately	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive **Covered Services**.	Hotline reports; internal reports; reports by **Health Networks**
M07	Other (please specify)	Any source
M08	**Member Pharmacy** Utilization	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
M09	Doctor Shopping	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
M10	Altered Prescription	**Provider** report; DEA report; **Pharmacy** report; **PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software

B. CalOptima may detect **Fraud**, **Waste**, or **Abuse** by an **FDR** in circumstances that include, but are not limited to, the following:

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program	**Provider** information not able to be verified during credentialing or contracting process; **Providers** on the excluded **Provider** list

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FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P02	Submission of claims for **Covered Services** that are substantially and demonstrably in excess of any individual's usual charges for such **Covered Services**	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
P03	Submission of claims for **Covered Services** that are not actually provided to the **Member** for which the claim is submitted	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software; verification survey; hotline
P04	Submission of claims for **Covered Services** that are in excess of the quantity that is **Medically Necessary**	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
P05	Submission of claims for **Covered Services** that are that are billed using a code that would result in greater payment than the code that reflects the **Covered Services**	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
P06	Submission of claims for **Covered Services** that is already included in the capitation rate	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software
P07	Submission of claims for **Covered Services** that are submitted for payment to both CalOptima and another third-party payer without full disclosure	**PBM** reports; data analytics; claims data; **Encounter** data; **FWA** software; payment by OHI
P08	Charging a **Member** in excess of allowable co-payments and deductibles for **Covered Services**	**Member** report; hotline report; oversight audits
P09	Billing a **Member** for **Covered Services** without obtaining written consent to bill for such service	**Member** report; hotline report; oversight audits
P10	Failure to disclose conflict of interest	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a **Member**	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Care Services	Oversight audit; report by regulatory body; hotline
P13	False certification of **Medical Necessity**	**Medical Record** review; claims data; **Encounter** data; **FWA** software
P14	Attributing a diagnosis code to a **Member** that does not reflect the **Member's** medical condition for the purpose of obtaining higher reimbursement	**Medical Record** review; claims data; **Encounter** data; **FWA** software
P15	False or inaccurate Minimum Standards or credentialing information	Hotline; credentialing or contracting process

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FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with clinical, **Encounter** or payment records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations	**Medical Record** review; claims data; **Encounter** data; **FWA** software

C. CalOptima may detect **Fraud**, **Waste**, or **Abuse** by an **Employee** in circumstances that include, but are not limited to, the following:

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a **Member's** identity or documentation of Medi-Cal eligibility to obtain services	Hotline report; Data analytics; Referrals to SIU
E02	Use of a **Member's** identity or documentation of Medi-Cal eligibility to obtain a gain	Hotline report, referrals to SIU
E03	**Employee** assistance to **Providers** with the submission of false claims for **Covered Services** that are not actually provided to the **Member** for which the claim is submitted	Hotline report; Referrals to SIU
E04	**Employee** deceptively accessing company confidential information for purpose of a gain	Hotline report; Data analytics; Referrals to SIU

C. Training

1. CalOptima's Office of Compliance shall provide regular training and education to **Employees** and **FDRs** regarding the process for detecting suspected **FWA**, the specific provisions regarding **FWA** under the False Claims Act, and the protections afforded to those who report such concerns in good faith and in accordance with CalOptima Policy HH.5004Δ: False Claims Act Education.

2. CalOptima shall provide regular **FWA** training and information sessions to:

   a. New **Employees**, upon hire;

   b. CalOptima **Employees**, on an annual basis; and

   c. **Health Networks**, on an annual basis.

3. CalOptima shall provide **Members** with information related to **FWA** through:

   a. The **Member** Handbook;

   b. Periodic communications; and

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c. The CalOptima website.

D. Detection

1. CalOptima may receive **Complaints** of suspected **FWA** from sources, including but not limited to:

   a. CalOptima's Compliance and Ethics Hotline;

   b. Claims data history:

   c. **Encounter** data;

   d. **Medical Records** audits;

   e. **Member** and **Provider Complaints**, appeals, and grievance reviews;

   f. Utilization Management reports;

   g. **Provider** utilization profiles;

   h. **Pharmacy** data;

   i. Monitoring and auditing activities;

   j. Monitoring external health care **FWA** cases and determining if CalOptima's **FWA** Program can be strengthened with information gleaned from the case activity; and/or

   k. Internal and external surveys, reviews, and audits.

2. The Office of Compliance shall provide oversight to the **Health Networks'** Compliance Programs to ensure that the programs are in place, are comprehensive, and in compliance with CalOptima contractual requirements.

3. CalOptima shall utilize "claims edits" in accordance with federal and state regulations, the **DHCS** Contract, and industry best practices, including but not limited to the National Correct Coding Initiative (NCCI).

4. CalOptima shall conduct data validation reviews by claims auditors within the Office of Compliance. These reviews are intended to detect any anomalies between items billed, items rendered, **Medical Records**, and all affiliated documentation related to the claims and **Encounters**.

5. CalOptima shall utilize data analytics including software to identify potential **FWA** cases. This data compares CalOptima claims and **Encounters** against national data to identify any suspected instances of **FWA**. These cases are forwarded to the Special Investigations Unit (SIU) for investigation.

6. CalOptima shall perform reviews on data samples to test for potential **FWA** through methods, including, but not limited to:

   a. Reviewing utilization by doctor, specialty, and geographic comparison;

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b. CalOptima's **Pharmacy** Department shall refer cases to the SIU Team for **Members** exhibiting drug seeking behavior or suspected of **FWA** issues related to **Pharmacy** services.

7. CalOptima shall implement a Service Verification Survey process to survey a sampling of **Members** as needed. The Service Verification process may be used to ensure that:

a. **Covered Services** that were billed were received;

b. Face-to-face services were provided for services/equipment/medications requiring recent or regular face-to-face appointments;

c. **Durable Medical Equipment (DME)** that were billed were received; and

d. Medications that were billed were received.

e. The focus of these surveys will vary as decided by the SIU and/or the Office of Compliance designated staff. The focus may be on a specific code, **Provider**, **Member** category, geographic area, and **DME** description, reports by other agencies of potential **FWA**, and industry findings and best practices.

E. Upon detection of suspected **Fraud**, **Waste**, and/or **Abuse**, the Office of Compliance shall review the suspected activity in accordance with CalOptima Policy HH.1107: **Fraud**, **Waste**, and **Abuse** Investigation and Reporting.

F. CalOptima shall treat the detection of suspected **Fraud**, **Waste**, or **Abuse** in a confidential manner, and shall not retaliate or make retribution against any CalOptima **Employee**, **FDR**, or **Member** for such detection, in accordance with CalOptima policy HH.3012Δ: Non-Retaliation for Reporting Violations.

IV. ATTACHMENTS

A. Suspected Fraud or Abuse Referral Form (English)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services for Medi-Cal
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Service (DHCS) for Cal MediConnect
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima PACE Program Agreement
E. CalOptima Contract for Health Care Services
F. CalOptima Policy HH.1107Δ: Fraud, Waste and Abuse Investigation and Reporting
G. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
H. CalOptima Policy HH.5004Δ: False Claims Act Education
I. CalOptima Policy GG.1423: Medication Quality Assurance Program
J. Department of Health Care Services All Plan Letter (APL) 19-012: Federal Drugs Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse
K. California Government Code 12650, California False Claims Act Title 31, United States Code (U.S.C.), §3730(h)
L. Title 42, Code of Federal Regulations (C.F.R.), §455.2
M. Welfare and Institutions Code, §§14026 and 14107.2

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N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1999	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	08/01/2000	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2004	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	01/01/2007	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Effective	01/01/2007	MA.9107	Fraud, Waste, and Abuse Detection	OneCare
Revised	02/01/2013	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare
Revised	04/01/2014	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	04/01/2014	MA.9107	Fraud, Waste, and Abuse Detection	OneCare
Revised	12/01/2014	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	09/01/2015	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2015	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	06/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	06/01/2016	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
Covered Service	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, 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. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). PACE: Items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132, except those services specifically excluded under the CalOptima PACE Program Agreement, Exhibit E, Attachment 1, Section 26.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

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Term	Definition
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Durable Medical Equipment (DME)	Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Employee	Any and all Employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
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.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Network	The contracted Health Networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
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
Member	A beneficiary who is enrolled in a CalOptima Program.

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Term	Definition
Other Health Coverage (OHC)	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.
Personal 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 un-emancipated minors.
Pharmacy	An area, place or premises licensed by the State Board of Pharmacy in which the profession of Pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
Pharmacy Benefit Manager (PBM)	An entity that provides Pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and Prior Authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
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.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist, or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures
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.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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INSTRUCTIONS FOR COMPLETING A SUSPECTED FRAUD OR ABUSE REFERRAL FORM

To submit a request to investigate suspected fraud or abuse, please complete a CalOptima Suspected Fraud or Abuse Referral Form. Examples of "Member" or "Provider" fraud or abuse are listed on the form. These are examples only. The list does not represent every situation in which fraud or abuse can take place.

Complete all applicable sections of the form. It is very important to complete the entire form so we can effectively investigate the issue.

If desired, requestor may remain anonymous; however, if the requestor does not provide his/her name and phone number, the CalOptima Office of Compliance will be unable to contact him/her if there are any questions about the information submitted, which may prevent completion of the investigation.

Submit the completed form with supporting documents to CalOptima's Office of Compliance via one of the following methods:

1. Email: Fraud@CalOptima.org
2. U.S. Mail: CalOptima
   Office of Compliance — SIU
   505 City Parkway West
   Orange, CA 92868
3. Fax: **1-714-481-6457**

MARK ALL CORRESPONDENCE AS "CONFIDENTIAL."

You may also report suspected fraud or abuse to CalOptima's Ethics and Compliance hotline, 24 hours a day, 7 days a week, toll-free at 1-877-837-4417. TDD/TTY users can call toll-free at 1-800-735-2929. We have staff that speak your language.

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

REFERRAL INFORMATION		
Date: _____		Notice involves suspected fraud or abuse by a:
Referred by: Name: _____	Title: _____	☐ Member
Dept.: _____	Phone#: _____	☐ Provider

MEMBER	PROVIDER
CalOptima Program: ☐Medi-Cal ☐OneCare ☐PACE ☐OneCare Connect	Provider Name:
Member Name:	Type of provider:
Member ID:	Provider ID #:
Address:	Address:
City: ZIP:	City: ZIP:
Date of service if applicable:	Date of service if applicable:
Member ID, if applicable:	If multiple members are involved, please attach a list.

Examples of suspected fraud or abuse:

- ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services and prescriptions (unless that person is an authorized representative who is presenting such information to obtain covered services on behalf of a member)
- ☐ Selling, loaning or giving a member's identity or documentation of eligibility to obtain covered services (other than to a family member to obtain covered services on behalf of a member)
- ☐ Falsely claiming eligibility
- ☐ Using a covered service for purposes other than the purposes for which it was prescribed, including use by an individual other than the member for whom the covered service was prescribed or provided
- ☐ Failing to report other health coverage
- ☐ Soliciting or receiving a kickback, bribe or rebate as an inducement to receive or not receive covered services
- ☐ Other (please specify) _____

Allegation of suspected fraud or abuse:

- ☐ Falsely claiming eligibility to participate in the CalOptima program.
- ☐ Submission of claims for covered services that are:
  - ☐ Substantially and demonstrably more than any individual's usual charges for such covered services
  - ☐ Not actually provided to the member for which the claim is submitted
  - ☐ More than the quantity that is medically necessary
  - ☐ Billed using a code that would result in greater payment than the code that reflects the covered service
  - ☐ Already included in capitation rate
  - ☐ Submitted for payment to both CalOptima and another third-party payer without full disclosure
- ☐ Charging a member in excess of allowable co-payments and deductibles for covered services
- ☐ Billing a member for covered services without obtaining written consent to bill for such services

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

	☐ Failure to disclose conflict of interest ☐ Receiving, soliciting or offering a kickback, bribe or rebate to refer or fail to refer a member ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS) ☐ False certification of medical necessity ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition to obtain higher reimbursement ☐ False or inaccurate Minimum Standards or credentialing information ☐ Submitting reports that contain unsubstantiated data, data that is inconsistent with records or has been altered in a manner that is inconsistent with policies, contracts, statutes or regulations. ☐ Other (please specify) _____

DOCUMENTATION (PLEASE ATTACH):
☐ Claims data ☐ Medical records ☐ Complaint, appeal or grievance ☐ UM reports ☐ Audit ☐ Other (please specify) _____ **Please provide a brief explanation of how the documentation provided supports concerns of fraudulent activity:** _____ **Please provide the root cause of this suspected fraudulent activity:** _____

OTHER RELEVANT INFORMATION (PLEASE ATTACH):
Are there any prior suspected fraud or abuse issues by this member, provider, pharmacy, other: _____ 1. ☐ No ☐ Yes. Please describe:
2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance SIU shall report as appropriate to local and state entities. If you do not receive an acknowledgement of receipt of this form within five (5) working days, please send an email to Fraud@CalOptima.org.

Policy ~~#:~~:	HH.1107Δ
Title:	**Fraud, Waste, and Abuse Investigation and Reporting**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*Michael Schrader* _____
Effective Date:	09/01/~~04~~2004
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

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I. PURPOSE

This policy establishes a process to investigate and report suspected **Fraud**, **Waste, or Abuse (FWA)** ~~in a CalOptima program~~committed by a **Member**, **Provider**, ~~Practitioner,~~ a CalOptima **Employee**, **First Tier, Downstream, and Related Entities (FDRs)**, ~~Billing Intermediary,~~ and CalOptima's **Health** ~~Network~~**Networks** involving a CalOptima program, in accordance with federal and state regulations and contractual requirements.

II. POLICY

~~A.~~ CalOptima maintains a zero-tolerance policy toward **FWA** by ~~any CalOptima~~a **Member**, a **Provider**, an **Employee** ~~or~~, an **FDR**.

A. ~~CalOptima~~ and ~~its FDRs~~/or a **Health Network**.

B. CalOptima shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of **Covered Services**, which include, but are not limited to, federal and state False Claims Acts~~,~~ and Anti-Kickback ~~statutes, prohibitions on~~laws, the federal Exclusion Statute, the federal Administrative Remedies Act, the federal Social Security Act laws prohibiting inducements to ~~beneficiaries,~~**Members**, the federal **Health Insurance Portability and Accountability Act (HIPAA)**, and other applicable statutes.

C. CalOptima **Employees** and its **FDRs** are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima program. CalOptima maintains a strict policy of non-retaliation and non-retribution toward **Employees** and its **FDRs** who make such reports in good faith. ~~CalOptima Employees and its FDRs are protected from retaliation under Title 31, United State Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections.~~

~~D. This policy is reviewed annually to ensure relevancy and accuracy, ensuring that CalOptima's FWA program are in alignment with industry best practices.~~

~~E.~~D. CalOptima shall establish a process for timely and reasonable investigation and reporting of suspected **FWA**, in accordance with this policy.

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

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~~F.~~E. CalOptima's Office of Compliance shall coordinate all activities associated with the investigation and reporting of suspected **FWA**.

~~G.~~F. CalOptima's Office of Compliance shall maintain a system for the review of suspect claims to detect and prevent **FWA**, in accordance with federal and state regulations, and to identify resulting overpayments for recoupment, in accordance with CalOptima ~~Policy~~Policies HH.5000Δ: Provider Overpayment Investigation and Determination and HH.1105Δ: Fraud, Waste and Abuse Detection.

G. ~~CalOptima shall cooperate~~CalOptima's Office of Compliance shall collaborate with the CalOptima Pharmacy Management Department, and other appropriate departments, to reduce controlled substances and opioid-related **Fraud**, **Abuse**, and misuse, as outlined in CalOptima Policy GG.1423: Medication Quality Assurance Program.

1. The CalOptima SIU shall investigate suspected **FWA** of prescription drugs, and/or controlled substances, in accordance with this Policy.

H. CalOptima shall coordinate and cooperate with the **Department of Health Care Services (DHCS)**, **Centers for Medicare & Medicaid (CMS)**, and law enforcement agencies related to any **FWA** investigations, or audits.

I. CalOptima shall conduct a preliminary investigation of any allegation of suspected **FWA** and shall report suspected **FWA** to the appropriate agency, in accordance with its contracts with **DHCS** and/or **CMS**, and this policy.

J. Upon determination of validity of the allegation, CalOptima shall refer suspected **FWA** to **DHCS** and/or **CMS** for further investigation, as appropriate.

~~K.~~ CalOptima's Office of Compliance shall maintain a database and a uniform filing system to maintain suspected **FWA** referrals, including reports, investigations, and correspondence, in accordance with CalOptima's **Compliance Program**.

K. ~~CalOptima's Office of Compliance shall develop data and other supporting evidence for a FWA investigation, consult with Legal Counsel, and function as~~ CalOptima's Office of Compliance shall ensure appropriate confidentiality of case files, or other documentation relating to any investigation of a suspected **FWA** case.

L. CalOptima's Office of Compliance shall function as the liaison between CalOptima and **DHCS**, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies, as appropriate, and other relevant entities.

~~M.A. CalOptima's Office of Compliance shall ensure appropriate confidentiality of case files, or other documentation relating to any investigation of a suspected **FWA** case.~~

~~N.~~M. CalOptima's Office of Compliance shall report the status and results of ~~all~~ suspected **FWA** investigations to CalOptima's Compliance Committee~~.~~ as appropriate.

N. CalOptima's Office of Compliance shall investigate, and report suspected **FWA**, in accordance with this policy.

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III. PROCEDURE

~~O. CalOptima shall fully coordinate and cooperate with DHCS, CMS, and other law enforcement agencies related to any FWA investigations, or audits, to support health oversight matters.~~

~~III. PROCEDURE~~

~~A. Reporting:~~

A. Reporting FWA to CalOptima:

1. CalOptima shall provide a method for CalOptima **Employees**, **FDRs**, and **Members** to anonymously report suspected **FWA** to the Office of Compliance. CalOptima **Employees** and its **FDRs** may call the Compliance and Ethics Hotline at (877) 837-4417 to anonymously report concerns regarding **Fraud**, **Waste**, and **Abuse**.

2. A CalOptima **Employee** who detects suspected **FWA** ~~shall~~may also complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

3. An **FDR** with a contractual obligation to report suspected **FWA** shall notify CalOptima of suspected **FWA**, in accordance with the terms and conditions of its contract and this policy.

B. Investigation of FWA:

~~P.~~A. ~~CalOptima's Office of Compliance shall investigate, and report suspected **FWA**, in accordance with this policy.~~

~~1. CalOptima shall report to DHCS all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Employees, FDRs, or Members. CalOptima shall conduct, complete and report to DHCS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within ten (10) business days of the date CalOptima first became aware of, or is in notice of, such activity.~~

~~4. For investigations involving OneCare, OneCare Connect, or PACE programs, CalOptima shall report to CMS via the NBI MEDIC all cases of suspected fraud and/or abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Employees, FDRs, or Members. CalOptima shall conduct, complete and report to CMS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within thirty (30) business days of the date CalOptima first became aware of, or is in notice of, such activity.~~

~~5. Referrals to **DHCS** and NBI MEDIC, where Special Investigation Unit (SIU) detection activities results in a reason to believe suspected Fraud or Abuse has occurred and requires further investigation by DHCS, shall be sent on the Form MC609 Confidential Report form. The MC609 form and attachments submitted to DHCS must, at a minimum, include:~~

~~f. Number of complaints of Fraud and Abuse submitted that warranted preliminary investigation;~~

~~g. For each complaint which warranted a preliminary investigation:~~

~~a. Name and/or SSN or CIN;~~

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~~b.a. Source of complaint;~~

~~c.a. Type of **Provider;**~~

~~d.a. Nature of complaint;~~

~~e.a. Approximate dollars involved if known; and~~

~~f. Legal and administrative disposition of the case.~~

~~h. For investigations involving the Medi-Cal program, the referral shall be submitted on a Medi-Cal Complaint Report (MC609) that can be sent to **DHCS** via secure email, secure facsimile, Federal Express with a tracking number or certified mail, in accordance with the instructions provided in Exhibit E of CalOptima's contract with the Department of Health Care Services (DHCS) for Medi-Cal.~~

~~i. For investigations involving the OneCare, OneCare Connect, or PACE programs, the referral shall be submitted on a Part D/MEDIC Complaint form that can be sent to CMS contractor, NBI MEDIC, via secure email, secure facsimile, FedEx with a tracking number, or certified mail. For investigations involving OneCare, OneCare Connect, or PACE program where the allegation is exclusively a compromised identification, the referral to NBI MEDIC shall be submitted on a MEDIC ID compromised form. CalOptima shall submit applicable police reports, investigation documentation (background, interviews, etc.), **Member** information, **Provider** enrollment data, confirmation of services, list items or services furnished by **Provider**, pharmaceutical data, and any other pertinent information.~~

~~B. Investigation:~~

1. Upon detection of suspected **FWA**, the Office of Compliance shall review the suspected activity using data from reports, including, but not limited to, the following:

   a. CalOptima's Compliance and Ethics Hotline, or other reporting mechanisms;

   b. Claims data history;

   c. Encounter data;

   d. **Member** and **Provider** complaints, appeals, and grievance reviews;

   e. **Medical Record** audits;

   f. Pharmacy data;

   g. Utilization Management reports;

   h. **Provider** utilization profiles;

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i. Monitoring and auditing activities;

j. Monitoring external health care **FWA** cases and determining if CalOptima's **FWA** program can be strengthened with information gleaned from the case activity; and/or

k. Internal and external ~~survey~~surveys, reviews, and audits.

~~2. For investigations involving the CalOptima Medi-Cal program, CalOptima shall complete the preliminary investigation, including the review of listed and other documents. CalOptima shall conduct, complete and report to DHCS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within ten (10) business days of the date CalOptima first became aware of, or is in notice of, such activity.~~

~~3. For investigations involving the OneCare, One Care Connect, or Program of All-Inclusive Care for the Elderly (PACE) programs, CalOptima shall complete the preliminary investigation, including the review of listed and other documents. CalOptima shall conduct, complete, and report to the CMS National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), the results of a preliminary investigation of the suspected fraud and/or abuse within thirty (30) business days of the date CalOptima first became aware of, or is in notice of, such activity.~~

~~4.~~2. For CalOptima **Employee** conduct investigations that involve potential **FWA**, a referral to SIU should be made by the CalOptima staff involved in the initial **Employee** conduct investigation. Each referral is considered on a case-by-case basis. The referral to SIU for **Employee** conduct investigations will authorize the SIU to have primary responsibility of the **Employee** conduct investigation as it relates to potential **FWA**.

~~5.~~3. ~~When included on the FWA Referral Form, or when~~When the **FWA** Investigator is able to determine the probable root cause of the suspected **FWA**, the information will be documented in the **Fraud** Tracking Database~~. Additionally, the FWA Investigator will track~~ and ~~trend on the root causes as part of the FWA Trend Analysis on a~~ may be reported during the quarterly ~~basis to the~~ **Compliance Committee**~~, when there are root causes that have been identified and able to be trended.~~ Meetings.

4. ~~For~~ If an investigation finds no component of FWA, and the ~~Medi-Cal Program, and~~actions investigated are more appropriately classified as non-compliance, the remediation shall be handled in accordance with CalOptima Policies HH.2005Δ: Corrective Actions Plans, HH.2002Δ: Sanctions, ~~and~~or GA.8022: Performance and Behavior Standards~~,~~.

5. CalOptima shall issue corrective actions to **Employees**~~,~~ and its **FDRs** related to validated instances of **FWA**. Corrective actions will be monitored by the **Compliance Committee**, or the Human Resources Department, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. If the validated instance of **FWA** is determined to be criminal in nature, ~~corrective action~~ actions may also include a referral to law enforcement.

6. The~~Should such corrective action need to be issued, the CalOptima~~ Office of Compliance will initiate review and discussion at the first **Compliance Committee** following the date ~~of~~

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~~identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report~~to which the alleged FWA has been investigated and yielded findings.

7. If CalOptima's SIU investigation yields findings involving a **FDR**, the SIU shall notify the impacted CalOptima department(s) and CalOptima **Health Network(s)**.

~~7.~~ For investigations involving ~~For the OneCare, OneCare Connect, or PACE programs, and in accordance with CalOptima Policies HH.2005Δ: Corrective Actions Plans, HH.2002Δ: Sanctions, and GA.8022: Performance and Behavior Standards, CalOptima shall issue corrective actions to Employees, and its FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Human Resources Department, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination, as appropriate. If the validated instance of FWA is determined to be criminal in nature, corrective action may also include a referral to law enforcement. Should such corrective action need to be issued, the CalOptima Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to CMS, or the date of FWA substantiation by CMS subsequent to the report.~~

8. suspected FWA of prescription drugs, including controlled substances, the CalOptima SIU will collaborate with the CalOptima Pharmacy Management Department during the investigation. If the investigation yields findings related to FWA, the SIU will work with Pharmacy Management and Quality Improvement to implement actions in accordance with CalOptima Policies GG.1425: Prescriber Restriction Program, GG.1416: Pharmacy Home Program, GG.1408: Pharmacy Audits and Reviews, GG.1615: Corrective Action Plan for Practitioners, and MA.6104: Opioid Medication Utilization Management.

The SIU

~~1. For investigations involving situations when **DHCS** notifies the CalOptima that a Credible Allegation of Fraud has been found against a Provider relating to the provision of Fee-For-Service (FFS) Medi-Cal services and that Provider is also part of the CalOptima network, CalOptima must take one (1) or more of the following options and submit supporting documentation to DHCS:~~

~~a. Terminate the Provider from its network;~~

~~b. Temporarily suspend the Provider from its network pending resolution of the Fraud allegation;~~

~~c. Temporarily suspend payment to the Provider pending resolution of the Fraud allegation; and/or~~

~~d. Conduct additional monitoring including audits of the Provider's claims history and future claims submissions for appropriate billing.~~

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8. The following is a list of potential FWA classifications for Member and Provider Fraud and Abuse Program, along with some examples of potential detection criteria that may be used to detect these types of suspected FWA:

MEMBER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to;
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M03	Making an unsubstantiated declaration of eligibility	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was described including use of such Covered Service	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other (please specify)	Any source
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software

PROVIDER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program	Provider information not able to be verified during credentialing or contracting process; providers on the excluded provider list
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services	PBM reports; data analytics; claims data; encounter data; FWA software
P03	Submission of claims for Covered Services that are not actually provided	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline

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PROVIDER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
	to the member for which the claim is submitted	
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary	PBM reports; data analytics; claims data; encounter data; FWA software
P05	Submission of claims for Covered Services that are that are billed using a code that would result in great payment than the code that reflects the covered services	PBM reports; data analytics; claims data; encounter data; FWA software
P06	Submission of claims for Covered Services that is already included in the capitation rate	PBM reports; data analytics; claims data; encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima and another third-party payer without full disclosure	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI
P08	Charging a member in excess of allowable co-payments and deductibles for Covered Services	Member report; hotline report; oversight audits
P09	Billing a member for Covered Services without obtaining written consent to bill for such service	Member report; hotline report; oversight audits
P10	Failure to disclose conflict of interest	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a member	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Care Services	Oversight audit; report by regulatory body; hotline
P13	False certification of Medical Necessity	Medical record review; claims data; encounter data; FWA software
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement	Medical record review; claims data; encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information	Hotline; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statues or regulations	Medical record review; claims data; encounter data; FWA software
P17	Other (please specify)	Any source

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~~PROVIDER FRAUD OR PROGRAM ABUSE~~		~~DETECTION CRITERIA Including but not limited to:~~
~~P18~~	~~Provider Pharmacy Utilization~~	~~PBM reports; data analytics; claims data; encounter data; FWA software~~
~~P19~~	~~Billing Medi-Cal Member for Services~~	~~Member report; hotline report; oversight audits~~
~~P20~~	~~Durable Medical Equipment- Covered Services that are not actually provided to beneficiary~~	~~Member report; hotline report; oversight audits; verification survey~~

~~EMPLOYEE FRAUD OR PROGRAM ABUSE~~		~~DETECTION CRITERIA Including but not limited to:~~
~~E01~~	~~Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services~~	~~Employees obtaining services on a Member's account. Hotline report. Data analytics. Referrals to SIU.~~
~~E02~~	~~Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain.~~	~~Employees obtaining unjust enrichment, funds, or other gain by selling Member's account information. Hotline report.~~
~~E03~~	~~Employee assistance to providers with the submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted.~~	~~Employees obtaining unjust enrichment, funds, or other gain from provider by using Member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.~~
~~E04~~	~~Employee deceptively accessing company confidential information for purpose of a gain.~~	~~Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.~~

9. ~~CalOptima Special Investigation Unit (SIU)~~ shall enter all documentation related to any suspected **FWA** case into the **Fraud** Tracking Database as soon as practicable and document the final disposition as soon as practicable, once the case has been determined to be closed.

C. Notices of a Credible Allegation of Fraud

1. For investigations involving situations when **DHCS** notifies CalOptima that a **Credible Allegation of Fraud** has been found against a **FDR** relating to the provision of Fee-For-Service (FFS) Medi-Cal services and that **FDR** is also part of the CalOptima network, CalOptima must take one (1) or more of the following options and submit supporting documentation to **DHCS**:

   a. Terminate the **FDR** from its network;

   b. Temporarily suspend the **FDR** from its network pending resolution of the **Fraud** allegation;

   c. Temporarily suspend payment to the **FDR** pending resolution of the **Fraud** allegation; and/or

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d. Conduct additional monitoring including audits of the **FDR's** claims history and future claims submissions for appropriate billing.

D. CalOptima Reporting to Regulators:

1. For investigations involving Medi-Cal, CalOptima shall report to **DHCS** all cases of suspected **Fraud** and/or **Abuse** where there is reason to believe that an incident of **Fraud** and/or **Abuse** has occurred by CalOptima **Employees**, **FDRs**, or **Members**. CalOptima shall conduct, complete and report to **DHCS**, the results of a preliminary investigation of the suspected **Fraud** and/or **Abuse** within ten (10) business days of the date CalOptima first became aware of, or is on notice of, such activity.

2. For investigations involving OneCare, OneCare Connect, or PACE programs, CalOptima shall report to **DHCS** in accordance with III.5. above, as well as to **CMS** via the Investigations MEDIC Complaint Form (I MEDIC) all cases of suspected **Fraud** and/or **Abuse** where there is reason to believe that an incident of **Fraud** and/or **Abuse** has occurred by CalOptima **Employees**, **FDRs**, or **Members**. CalOptima shall conduct a preliminary investigation and report to **CMS** within thirty (30) business days of the date potential Fraudulent or abusive activity is identified.

3. Referrals to **DHCS** and **CMS**, where Special Investigation Unit (SIU) detection activities results in a reason to believe suspected **Fraud** or **Abuse** has occurred and requires further investigation, shall include at a minimum:

a. Identifying information of the subject;

b. Source of complaint;

c. Type of **Provider**;

d. Nature of complaint;

e. Approximate dollars involved if known; and

f. Legal and administrative disposition of the case.

4. For investigations involving the Medi-Cal program, the referral shall be submitted on a Medi-Cal Complaint Report (MC609) that can be sent to **DHCS** via secure email, secure facsimile, Federal Express with a tracking number, or certified mail, in accordance with the instructions provided in Exhibit E of CalOptima's contract with the **Department of Health Care Services (DHCS)** for Medi-Cal.

~~10.~~ For investigations involving the OneCare, OneCare Connect, or PACE programs, the referral shall be submitted on a Part D/I MEDIC Complaint form that can be sent to **CMS** contractor via secure email, secure facsimile, Federal Express with a tracking number, or certified mail. For investigations involving OneCare, OneCare Connect, or PACE program where the allegation is exclusively a compromised identification, the referral to **CMS** shall be submitted on a I MEDIC ID Compromised ID Report Form via secure email, secure facsimile, Federal Express with a tracking number, or certified mail. CalOptima shall submit applicable police reports, investigation documentation

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(background, interviews, etc.), **Member** information, **Provider** enrollment data, confirmation of services, list items or services furnished by **Provider**, pharmaceutical data, and any other pertinent information~~Compliance Action/Outcomes may include, but are not limited to:~~

~~C01~~	~~Contract amendment~~
~~C02~~	~~Corrective action plan~~
~~C03~~	~~Education~~
~~C04~~	~~Focused Audit~~
~~C05~~	~~Investigation~~
~~C06~~	~~Monitoring~~
~~C07~~	~~New Policy~~
~~C08~~	~~Policy Revision~~
~~C09~~	~~Prepayment Review~~
~~C10~~	~~Process Review~~
~~C100~~	~~Referred to CalOptima Legal~~
~~C101~~	~~No Fraud Folder Created~~
~~C102~~	~~Criminal Filing- Pending~~
~~C11~~	~~Criminal Filing- Conviction~~
~~C111~~	~~Criminal Filing- Exonerated~~
~~C12~~	~~Non-Criminal Action Taken~~
~~C13~~	~~Does not meet prosecutorial guidelines~~
~~C14~~	~~Technical issues- resolved~~
~~C15~~	~~Insufficient evidence of fraud~~
~~C16~~	~~Allegations/Violation confirmed: Warning Letter Issued~~
~~C18~~	~~Allegations/Violation confirmed: Administrative Action~~
~~C19~~	~~Allegations/Violation confirmed: Warning Letter & Administrative Action~~
~~C20~~	~~Administrative Error~~
~~C21~~	~~Administrative Action~~
~~C22~~	~~Unable to establish violation of the Medi-Cal Program~~
~~C23~~	~~Medi-Cal Usage Minimal~~
~~C24~~	~~DHCS Referred to Other Agency~~
~~C26~~	~~Criminal Filing~~
~~C98~~	~~No Action Taken~~
~~C99~~	~~Other: (Explain)~~

~~IV. ATTACHMENTS~~

~~5. .~~

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)
B. Form MC609 - Confidential Medi-Cal Complaint Report form
C. CalOptima Referral to MEDIC
D. CalOptima Referral to MEDIC ID Compromised

~~V. REFERENCES~~

~~A. California Business and Professions Code, §4040~~

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~~B.~~A. ~~California Government Code 12650, California False Claims Act~~

V. REFERENCE(S)

~~C.~~A. CalOptima Compliance Plan
~~D.~~B. CalOptima Contract for Health Care Services
~~E.~~C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~F.~~D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Service (DHCS) for Cal MediConnect
~~G.~~F. CalOptima PACE Program Agreement
~~H.~~G. CalOptima Policy GA.8022: Performance and Behavior Standards
~~I.~~H. CalOptima Policy HH.1105Δ: Fraud, Waste, and Abuse Detection
~~J.~~I. CalOptima Policy HH.2002Δ: ~~Sanction~~Sanctions
~~K.~~J. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~L.~~K. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
L. CalOptima Policy GG.1425: Prescriber Restriction Program
M. CalOptima Policy GG.1416: Pharmacy Home Program
N. CalOptima Policy GG.1408: Pharmacy Audits and Reviews
O. CalOptima Policy MA.6104: Opioid Medication Utilization Management
P. Department of Health Care Services All Plan Letter (APL) 19-012: Federal Drugs Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse
~~M.~~A. ~~CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Service (DHCS) for Cal MediConnect~~
~~N.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required Following Notice of a Credible Allegation of Fraud
~~O.~~R. Medi-Cal Managed Care Division (MMCD) All Plan Letter 03-011: Fraud Referral Procedure to Audits and Investigations (~~AI~~A&I)
~~P.~~S. Medicare Managed Care Manual, Chapters 9 and 21
~~Q.~~T. Title 31, United States Code, §3730(h), for False Claims Act complaints
~~R.~~U. Title 42, Code of Federal Regulations, §455.2
V. California Government Code 12650, California False Claims Act
~~S.~~W. Welfare and Institutions Code, §14043.1(a)

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

A. 08/01/16: Department of Health Care Services (DHCS)

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

~~A. 12/06/18: Regular Meeting of the CalOptima Board of Directors~~
~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors~~
~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors~~

~~REVIEW/~~

~~VIII.~~I. ~~REVISION HISTORY~~

Date	Meeting
12/06/18~~Date~~	Regular Meeting of the CalOptima Board of Directors~~Line(s) of Business~~
12/07/17	Regular Meeting of the CalOptima Board of Directors
12/01/16	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2004	HH.1107	Fraud and Abuse Investigation and Reporting	Medi-Cal
Effective	01/01/2007	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	01/01/2008	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2008	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	12/01/2009	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2010	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	02/01/2013	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	02/01/2013	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	07/01/2014	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2014	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect
Revised	09/01/2015	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2015	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2016	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9108	Fraud, Waste, and Abuse Investigation and Reporting	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the ~~provider~~Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from ~~fraud~~Fraud, because the distinction between "~~fraud~~Fraud" and "~~abuse~~Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Covered Service	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, 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. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. OneCare Connect:

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Term	Definition
	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). PACE: Items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132, except those services specifically excluded under the CalOptima PACE Program Agreement, Exhibit E, Attachment 1, Section 26.
Credible Allegation of Fraud	A ~~credible allegation~~Credible Allegation of ~~fraud~~Fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through ~~provider~~Provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate ~~provider~~Provider of both health and administrative services.
Employee	Any and all ~~employees~~Employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary ~~employees~~Employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted ~~providers~~Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortiums, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to ~~defraud~~deFraud any health care benefit program or to obtain (by means of false or ~~fraudulent~~Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	The contracted ~~health networks~~Health Networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

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Term	Definition
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.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A beneficiary who is enrolled in a CalOptima Program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient ~~compliance programs~~Compliance Programs; performing drug utilization review; and operating disease management programs.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary ~~provider~~Provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.1107Δ
Title:	**Fraud, Waste, and Abuse Investigation and Reporting**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*Michael Schrader* _____
Effective Date:	09/01/2004
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

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I. PURPOSE

This policy establishes a process to investigate and report suspected **Fraud**, **Waste, or Abuse (FWA)** committed by a **Member**, **Provider**, a CalOptima **Employee**, **First Tier, Downstream, and Related Entities (FDRs)**, and CalOptima's **Health Networks** involving a CalOptima program, in accordance with federal and state regulations and contractual requirements.

II. POLICY

A. CalOptima maintains a zero-tolerance policy toward **FWA** by a **Member**, a **Provider**, an **Employee**, an **FDR** and/or a **Health Network**.

B. CalOptima shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of **Covered Services**, which include, but are not limited to, federal and state False Claims Acts and Anti-Kickback laws, the federal Exclusion Statute, the federal Administrative Remedies Act, the federal Social Security Act laws prohibiting inducements to **Members**, the federal **Health Insurance Portability and Accountability Act (HIPAA)**, and other applicable statutes.

C. CalOptima **Employees** and its **FDRs** are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima program. CalOptima maintains a strict policy of non-retaliation and non-retribution toward **Employees** and its **FDRs** who make such reports in good faith.

D. CalOptima shall establish a process for timely and reasonable investigation and reporting of suspected **FWA**, in accordance with this policy.

E. CalOptima's Office of Compliance shall coordinate all activities associated with the investigation and reporting of suspected **FWA**.

F. CalOptima's Office of Compliance shall maintain a system for the review of suspect claims to detect and prevent **FWA**, in accordance with federal and state regulations, and to identify resulting overpayments for recoupment, in accordance with CalOptima Policies HH.5000Δ: Provider Overpayment Investigation and Determination and HH.1105Δ: Fraud, Waste and Abuse Detection.

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

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G. CalOptima's Office of Compliance shall collaborate with the CalOptima Pharmacy Management Department, and other appropriate departments, to reduce controlled substances and opioid-related **Fraud**, **Abuse**, and misuse, as outlined in CalOptima Policy GG.1423: Medication Quality Assurance Program.

1. The CalOptima SIU shall investigate suspected **FWA** of prescription drugs, and/or controlled substances, in accordance with this Policy.

H. CalOptima shall coordinate and cooperate with the **Department of Health Care Services (DHCS)**, **Centers for Medicare & Medicaid (CMS)**, and law enforcement agencies related to any **FWA** investigations, or audits.

I. CalOptima shall conduct a preliminary investigation of any allegation of suspected **FWA** and shall report suspected **FWA** to the appropriate agency, in accordance with its contracts with **DHCS** and/or **CMS**, and this policy.

J. Upon determination of validity of the allegation, CalOptima shall refer suspected **FWA** to **DHCS** and/or **CMS** for further investigation, as appropriate.

K. CalOptima's Office of Compliance shall maintain a database and a uniform filing system to maintain suspected **FWA** referrals, including reports, investigations, and correspondence, in accordance with CalOptima's **Compliance Program**. CalOptima's Office of Compliance shall ensure appropriate confidentiality of case files, or other documentation relating to any investigation of a suspected **FWA** case.

L. CalOptima's Office of Compliance shall function as the liaison between CalOptima and **DHCS**, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies, as appropriate, and other relevant entities.

M. CalOptima's Office of Compliance shall report the status and results of suspected **FWA** investigations to CalOptima's Compliance Committee as appropriate.

N. CalOptima's Office of Compliance shall investigate, and report suspected **FWA**, in accordance with this policy.

III. PROCEDURE

A. Reporting FWA to CalOptima:

1. CalOptima shall provide a method for CalOptima **Employees**, **FDRs**, and **Members** to anonymously report suspected **FWA** to the Office of Compliance. CalOptima **Employees** and its **FDRs** may call the Compliance and Ethics Hotline at (877) 837-4417 to anonymously report concerns regarding **Fraud**, **Waste**, and **Abuse**.

2. A CalOptima **Employee** who detects suspected **FWA** may also complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

3. An **FDR** with a contractual obligation to report suspected **FWA** shall notify CalOptima of suspected **FWA**, in accordance with the terms and conditions of its contract and this policy.

B. Investigation of FWA:

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1. Upon detection of suspected **FWA**, the Office of Compliance shall review the suspected activity using data from reports, including, but not limited to, the following:

    a. CalOptima's Compliance and Ethics Hotline, or other reporting mechanisms;

    b. Claims data history;

    c. Encounter data;

    d. **Member** and **Provider** complaints, appeals, and grievance reviews;

    e. **Medical Record** audits;

    f. Pharmacy data;

    g. Utilization Management reports;

    h. **Provider** utilization profiles;

    i. Monitoring and auditing activities;

    j. Monitoring external health care **FWA** cases and determining if CalOptima's **FWA** program can be strengthened with information gleaned from the case activity; and/or

    k. Internal and external surveys, reviews, and audits.

2. For CalOptima **Employee** conduct investigations that involve potential **FWA**, a referral to SIU should be made by the CalOptima staff involved in the initial **Employee** conduct investigation. Each referral is considered on a case-by-case basis. The referral to SIU for **Employee** conduct investigations will authorize the SIU to have primary responsibility of the **Employee** conduct investigation as it relates to potential **FWA**.

3. When the **FWA** Investigator is able to determine the probable root cause of the suspected **FWA**, the information will be documented in the **Fraud** Tracking Database and may be reported during the quarterly **Compliance Committee** Meetings.

4. If an investigation finds no component of FWA, and the actions investigated are more appropriately classified as non-compliance, the remediation shall be handled in accordance with CalOptima Policies HH.2005Δ: Corrective Actions Plans, HH.2002Δ: Sanctions, or GA.8022: Performance and Behavior Standards.

5. CalOptima shall issue corrective actions to **Employees** and its **FDRs** related to validated instances of **FWA**. Corrective actions will be monitored by the **Compliance Committee**, or the Human Resources Department, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. If the validated instance of **FWA** is determined to be criminal in nature, actions may also include a referral to law enforcement.

6. The Office of Compliance will initiate review and discussion at the first **Compliance Committee** following the date to which the alleged FWA has been investigated and yielded findings.

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7. If CalOptima's SIU investigation yields findings involving a **FDR**, the SIU shall notify the impacted CalOptima department(s) and CalOptima **Health Network(s)**.

8. For investigations involving suspected FWA of prescription drugs, including controlled substances, the CalOptima SIU will collaborate with the CalOptima Pharmacy Management Department during the investigation. If the investigation yields findings related to FWA, the SIU will work with Pharmacy Management and Quality Improvement to implement actions in accordance with CalOptima Policies GG.1425: Prescriber Restriction Program, GG.1416: Pharmacy Home Program, GG.1408: Pharmacy Audits and Reviews, GG.1615: Corrective Action Plan for Practitioners, and MA.6104: Opioid Medication Utilization Management.

9. The SIU
9. shall enter all documentation related to any suspected **FWA** case into the **Fraud** Tracking Database as soon as practicable and document the final disposition as soon as practicable, once the case has been determined to be closed.

C. Notices of a Credible Allegation of Fraud

1. For investigations involving situations when **DHCS** notifies CalOptima that a **Credible Allegation of Fraud** has been found against a **FDR** relating to the provision of Fee-For-Service (FFS) Medi-Cal services and that **FDR** is also part of the CalOptima network, CalOptima must take one (1) or more of the following options and submit supporting documentation to **DHCS**:

   a. Terminate the **FDR** from its network;

   b. Temporarily suspend the **FDR** from its network pending resolution of the **Fraud** allegation;

   c. Temporarily suspend payment to the **FDR** pending resolution of the **Fraud** allegation; and/or

   d. Conduct additional monitoring including audits of the **FDR's** claims history and future claims submissions for appropriate billing.

D. CalOptima Reporting to Regulators:

1. For investigations involving Medi-Cal, CalOptima shall report to **DHCS** all cases of suspected **Fraud** and/or **Abuse** where there is reason to believe that an incident of **Fraud** and/or **Abuse** has occurred by CalOptima **Employees**, **FDRs**, or **Members**. CalOptima shall conduct, complete and report to **DHCS**, the results of a preliminary investigation of the suspected **Fraud** and/or **Abuse** within ten (10) business days of the date CalOptima first became aware of, or is on notice of, such activity.

2. For investigations involving OneCare, OneCare Connect, or PACE programs, CalOptima shall report to **DHCS** in accordance with III.5. above, as well as to **CMS** via the Investigations MEDIC Complaint Form (I MEDIC) all cases of suspected **Fraud** and/or **Abuse** where there is reason to believe that an incident of **Fraud** and/or **Abuse** has occurred by CalOptima **Employees**, **FDRs**, or **Members**. CalOptima shall conduct a preliminary investigation and report to **CMS** within thirty (30) business days of the date potential Fraudulent or abusive activity is identified.

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3. Referrals to **DHCS** and **CMS**, where Special Investigation Unit (SIU) detection activities results in a reason to believe suspected **Fraud** or **Abuse** has occurred and requires further investigation, shall include at a minimum:

   a. Identifying information of the subject;

   b. Source of complaint;

   c. Type of **Provider**;

   d. Nature of complaint;

   e. Approximate dollars involved if known; and

   f. Legal and administrative disposition of the case.

4. For investigations involving the Medi-Cal program, the referral shall be submitted on a Medi-Cal Complaint Report (MC609) that can be sent to **DHCS** via secure email, secure facsimile, Federal Express with a tracking number, or certified mail, in accordance with the instructions provided in Exhibit E of CalOptima's contract with the **Department of Health Care Services (DHCS)** for Medi-Cal.

5. For investigations involving the OneCare, OneCare Connect, or PACE programs, the referral shall be submitted on a Part D/I MEDIC Complaint form that can be sent to **CMS** contractor via secure email, secure facsimile, Federal Express with a tracking number, or certified mail. For investigations involving OneCare, OneCare Connect, or PACE program where the allegation is exclusively a compromised identification, the referral to **CMS** shall be submitted on a I MEDIC ID Compromised ID Report Form via secure email, secure facsimile, Federal Express with a tracking number, or certified mail. CalOptima shall submit applicable police reports, investigation documentation (background, interviews, etc.), **Member** information, **Provider** enrollment data, confirmation of services, list items or services furnished by **Provider**, pharmaceutical data, and any other pertinent information
5. .

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)
B. Form MC609 - Confidential Medi-Cal Complaint Report form
C. CalOptima Referral to MEDIC
D. CalOptima Referral to MEDIC ID Compromised

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract for Health Care Services
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Service (DHCS) for Cal MediConnect
F. CalOptima PACE Program Agreement
G. CalOptima Policy GA.8022: Performance and Behavior Standards

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H. CalOptima Policy HH.1105Δ: Fraud, Waste, and Abuse Detection
I. CalOptima Policy HH.2002Δ: Sanctions
J. CalOptima Policy HH.2005Δ: Corrective Action Plan
K. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
L. CalOptima Policy GG.1425: Prescriber Restriction Program
M. CalOptima Policy GG.1416: Pharmacy Home Program
N. CalOptima Policy GG.1408: Pharmacy Audits and Reviews
O. CalOptima Policy MA.6104: Opioid Medication Utilization Management
P. Department of Health Care Services All Plan Letter (APL) 19-012: Federal Drugs Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required Following Notice of a Credible Allegation of Fraud
R. Medi-Cal Managed Care Division (MMCD) All Plan Letter 03-011: Fraud Referral Procedure to Audits and Investigations (A&I)
S. Medicare Managed Care Manual, Chapters 9 and 21
T. Title 31, United States Code, §3730(h), for False Claims Act complaints
U. Title 42, Code of Federal Regulations, §455.2
V. California Government Code 12650, California False Claims Act
W. Welfare and Institutions Code, §14043.1(a)

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VI. REGULATORY AGENCY APPROVAL(S)

A. 08/01/16: Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/06/18	Regular Meeting of the CalOptima Board of Directors
12/07/17	Regular Meeting of the CalOptima Board of Directors
12/01/16	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2004	HH.1107	Fraud and Abuse Investigation and Reporting	Medi-Cal
Effective	01/01/2007	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	01/01/2008	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2008	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	12/01/2009	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2010	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	02/01/2013	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	02/01/2013	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	07/01/2014	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2014	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect
Revised	09/01/2015	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2015	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect PACE
Revised	06/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2016	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9108	Fraud, Waste, and Abuse Investigation and Reporting	OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/07/2017	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE

IX.

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Covered Service	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, 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. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).

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Term	Definition
	PACE: Items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132, except those services specifically excluded under the CalOptima PACE Program Agreement, Exhibit E, Attachment 1, Section 26.
Credible Allegation of Fraud	A Credible Allegation of Fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through Provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Employee	Any and all Employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortiums, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to deFraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	The contracted Health Networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
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.
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.

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Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient Compliance Programs; performing drug utilization review; and operating disease management programs.
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.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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CONFIDENTIAL

INSTRUCTIONS FOR COMPLETING A SUSPECTED FRAUD OR ABUSE REFERRAL FORM

To submit a request to investigate suspected fraud or abuse, please complete a CalOptima Suspected Fraud or Abuse Referral Form. Examples of "Member" or "Provider" fraud or abuse are listed on the form. These are examples only. The list does not represent every situation in which fraud or abuse can take place.

Complete all applicable sections of the form. It is very important to complete the entire form so we can effectively investigate the issue.

If desired, requestor may remain anonymous; however, if the requestor does not provide his/her name and phone number, the CalOptima Office of Compliance will be unable to contact him/her if there are any questions about the information submitted, which may prevent completion of the investigation.

Submit the completed form with supporting documents to CalOptima's Office of Compliance via one of the following methods:

1. Email: Fraud@CalOptima.org
2. U.S. Mail: CalOptima
   Office of Compliance — SIU
   505 City Parkway West
   Orange, CA 92868
3. Fax: **1-714-481-6457**

MARK ALL CORRESPONDENCE AS "CONFIDENTIAL."

You may also report suspected fraud or abuse to CalOptima's Ethics and Compliance hotline, 24 hours a day, 7 days a week, toll-free at 1-877-837-4417. TDD/TTY users can call toll-free at 1-800-735-2929. We have staff that speak your language.

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

REFERRAL INFORMATION		
Date: _____		Notice involves suspected fraud or abuse by a:
Referred by: Name: _____	Title: _____	☐ Member
Dept.: _____	Phone#: _____	☐ Provider

MEMBER	PROVIDER
CalOptima Program: ☐Medi-Cal ☐OneCare ☐PACE ☐OneCare Connect	Provider Name:
Member Name:	Type of provider:
Member ID:	Provider ID #:
Address:	Address:
City: ZIP:	City: ZIP:
Date of service if applicable:	Date of service if applicable:
Member ID, if applicable:	If multiple members are involved, please attach a list.

Examples of suspected fraud or abuse:

- ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services and prescriptions (unless that person is an authorized representative who is presenting such information to obtain covered services on behalf of a member)
- ☐ Selling, loaning or giving a member's identity or documentation of eligibility to obtain covered services (other than to a family member to obtain covered services on behalf of a member)
- ☐ Falsely claiming eligibility
- ☐ Using a covered service for purposes other than the purposes for which it was prescribed, including use by an individual other than the member for whom the covered service was prescribed or provided
- ☐ Failing to report other health coverage
- ☐ Soliciting or receiving a kickback, bribe or rebate as an inducement to receive or not receive covered services
- ☐ Other (please specify) _____

Allegation of suspected fraud or abuse:

- ☐ Falsely claiming eligibility to participate in the CalOptima program.
- ☐ Submission of claims for covered services that are:
  - ☐ Substantially and demonstrably more than any individual's usual charges for such covered services
  - ☐ Not actually provided to the member for which the claim is submitted
  - ☐ More than the quantity that is medically necessary
  - ☐ Billed using a code that would result in greater payment than the code that reflects the covered service
  - ☐ Already included in capitation rate
  - ☐ Submitted for payment to both CalOptima and another third-party payer without full disclosure
- ☐ Charging a member in excess of allowable co-payments and deductibles for covered services
- ☐ Billing a member for covered services without obtaining written consent to bill for such services

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

	☐ Failure to disclose conflict of interest ☐ Receiving, soliciting or offering a kickback, bribe or rebate to refer or fail to refer a member ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS) ☐ False certification of medical necessity ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition to obtain higher reimbursement ☐ False or inaccurate Minimum Standards or credentialing information ☐ Submitting reports that contain unsubstantiated data, data that is inconsistent with records or has been altered in a manner that is inconsistent with policies, contracts, statutes or regulations. ☐ Other (please specify) _____

DOCUMENTATION (PLEASE ATTACH):
☐ Claims data ☐ Medical records ☐ Complaint, appeal or grievance ☐ UM reports ☐ Audit ☐ Other (please specify) _____ **Please provide a brief explanation of how the documentation provided supports concerns of fraudulent activity:** _____ **Please provide the root cause of this suspected fraudulent activity:** _____

OTHER RELEVANT INFORMATION (PLEASE ATTACH):
Are there any prior suspected fraud or abuse issues by this member, provider, pharmacy, other: _____ 1. ☐ No ☐ Yes. Please describe:
2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance SIU shall report as appropriate to local and state entities. If you do not receive an acknowledgement of receipt of this form within five (5) working days, please send an email to Fraud@CalOptima.org.

CONFIDENTIAL
MEDI-CAL COMPLAINT REPORT

GENERAL INTAKE INFORMATION - Agency Receiving Complaint		
☐ DHCS ☐ County ☐ Other (specify)		
Name of Staff Taking Complaint:	Title:	
Agency Name (if other than DHCS):	Address if other than DHCS:	
Telephone Number:	Email:	
How complaint was received:	Time & Date received:	Type of complaint: ☐ Provider ☐ Recipient ☐ Drug ☐ IHSS ☐ Other

COMPLAINANT INFORMATION		
Name of Person Reporting Complaint:	Email:	Phone:
Address:	City & Zip:	

SUBJECT INFORMATION		
Subject Name:	Address:	City & Zip:
Subject Phone Number:	Email:	

Recipient Name:	Social Security Number:	Date of Birth:
Address: (Number, Street)	City & Zip	Phone:
Provider Name & DBA:	NPI, Provider Number, or SSN	Date of Birth:(IHSS)
Address: (number, street)	City, State	Phone:
Relationship to recipient:(IHSS)	Other information:	

NATURE OF COMPLAINT:

(Attach additional sheets if necessary)

COMPLAINT PROCESSED FOR INVESTIGATION: (For DHCS IB Use Only)		
Possible Statute, Regulation, Policy, Or Code Violation:	Code Description:	Open Date:
	Date Assigned by PAU:	PAU Internal Tracking Number:
☐ Supporting Documents	Case Number:	
☐ Credible Allegation of Fraud	Supervisor Assigned:	Date:
☐ Est. Medi-Cal Program Loss:	Investigator Assigned:	Date:
☐ Referral to DOJ Date:	☐ Referral to other Agency:	Date:

Qlarant

Investigations MEDIC Complaint Form

Instruction: The purpose of this form is to report complaints of fraud, waste, and abuse in the Medicare Parts C & D Programs. A representative from Qlarant may contact you upon receipt of this complaint, so please be sure to furnish sufficient contact information. **Please enter description of findings/allegations on next page.**

Date of Referral: _____

Please designate as a Part C or Part D issue:

- ◯ Medicare Advantage Issue (Part C)
- ◯ Prescription Drug Benefit Issue (Part D)
- ◯ Both Part C and Part D Issue

Complainant Contact Information:

Name: _____ Phone: _____ Fax: _____

Email: _____

Submitted By (Select One) ◯ Plan ◯ PBM ◯ UPIC ◯ Other on behalf of (if applicable):

_____

Complainant Organization Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Plan Name/Contract # (if applicable): _____

Plan Tracking # (if applicable): _____

Parent Organization (if applicable): _____

Pharmacy Benefit Manager (if applicable): _____

Beneficiary Information:

Name: _____ Phone: _____

HICN#: _____ MBI #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Primary language (if other than English): _____

Medicare Plan Name: _____ Member ID#: _____

Is the Beneficiary a Subject? ◯ No ◯ Yes ◯ Unknown

Do you have any Contact Reports on the beneficiary? ◯ No ◯ Yes ◯ Unknown

To ensure compliance with all applicable laws, do not send Protected Health Information (PHI) via email.

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Please fax this form to 410-819-8698, email to I-MEDICComplaints@qlarant.com, call 877-7SAFERX, or mail to Qlarant, Inc., 28464 Marlboro Avenue, Easton, MD 21601-2732, Attn: I-MEDIC

Qlarant

Investigations MEDIC Complaint Form

Description of Subject/Suspects of Fraud:

Name:_____ Tax ID (TIN):_____ NPI: _____

DEA#:_____ Medicare Provider #: _____

Business (DBA): _____ Phone#:_____

Address:_____ City: _____ State:_____ Zip:_____

Please describe type of business or physician specialty: _____

Complaint Details:

Prior MEDIC Case Number (if applicable): _____

Period of Review: _____

Was this matter forwarded to Law Enforcement?

No Yes If yes, type: OIG FBI Local

Was PLATO used? No Yes

Potential **MEDICARE** program exposure:

Part C program exposure: Billed $ Paid $

Part D program exposure: Billed $ Paid $

Did you receive Medical Records? No Yes

If yes, have you completed a Medical Record Review? No Yes

Have you reported Patient Harm in this matter to another agency? No Yes

Description of Findings/Allegations: (Please provide a detailed description of the nature of the fraud issue including the following: description of fraudulent activity; CPT codes involved; states where the fraud activity took place; description of individuals and/or businesses involved in the alleged illegal activity; dates that the fraud occurred; names and contact information for victims; and copies of documentation regarding the fraudulent activity including letters, advertising, etc.):

To ensure compliance with all applicable laws, do not send Protected Health Information (PHI) via email.

Please fax this form to 410-819-8698, email to I-MEDICComplaints@qlarant.com, call 877-7SAFERX, or mail to Qlarant, Inc., 28464 Marlboro Avenue, Easton, MD 21601-2732, Attn: I-MEDIC

I-MEDIC Compromised ID Report Form

Instructions: The purpose of this form is to report compromised Health Insurance Claim Numbers (HICNs), and/or Medicare Beneficiary Identifiers (MBIs); prescribing provider identifiers, or dispensing provider identifiers in the Medicare Parts C & D programs. Qlarant may contact you upon receipt of this report, so please be sure to furnish sufficient contact information. Please supply one compromised subject per form. To ensure compliance with all applicable laws, please do not send Protected Health Information (PHI) via email.

Please fax this form to 410-819-8698, Attn: Qlarant, Investigations MEDIC, Complaints Manager, or email it as an encrypted attachment to I-MEDICComplaints@qlarant.com.

Submitter Contact Information

Name: _____ Phone: _____ Fax: _____

Organization: _____ Email: _____

Address: _____ City: _____State: _____ Zip:_____

Compromised ID Information:

Type of entity: ◯ Beneficiary ◯ Prescriber/Provider ◯ Pharmacy

Description of Identifier which has been compromised (e.g. HICN, MBI, DEA NPI, NCPDP):

Identifier(s) which has been compromised:

Name of entity or individual:

Address of entity or individual: City: State:

Type of issue: ◯ Part C Issue ◯ Part D Issue ◯ Part C and D Issue

Report Details:

Please provide any information regarding how the number was compromised, subjects involved, etc. This may include a description of how the theft occurred, dates that the fraud occurred, description of individuals and/or businesses involved in the alleged activity, names and contact information for victims, and copies of documentation regarding the fraudulent activity including letters, advertising, attestations, affidavits, verification forms, etc. (enter details on page 2).

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Policy ~~#:~~:	HH.5000Δ
Title:	**Provider Overpayment Investigation and Determination**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse — Special Investigations Unit
CEO Approval:	*Michael Schrader* _____
Effective Date:	12/01/~~16~~2016
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

FOR 2019 2/5 BOD REVIEW

I. PURPOSE

This policy establishes an effective system for the review of suspect claims to detect and prevent **Fraud**, **Waste**, and **Abuse** (**FWA**) within a CalOptima program, in accordance with federal and state regulations, and to identify resulting **Overpayments** for recoupment.

II. POLICY

A. The CalOptima Special Investigations Unit (SIU) shall be responsible for identifying **Overpayments** for recoupment opportunities that may emerge in the course of ~~a~~an **FWA** investigation.

B. During the course of an investigation, the SIU team shall review claims, review **Medical Records** and other records, and/or ~~billing activity~~conduct interviews or surveys to either verify if services were rendered, or if services were appropriately billed, as applicable.

C. CalOptima may receive complaints of suspected **FWA** from any of the following sources, including but not limited to:

1. Compliance and Ethics Hotline;
2. Internal audits;
3. Internal operational reviews;
4. External audits, including audits conducted by consultants and regulatory agencies;
5. **FWA** software runs;
6. **Pharmacy Benefits Manager (PBM)**;
7. Compliance Committee;
8. Audit & Oversight Committee (AOC);

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

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9. Internal department referrals;

10. Claims auditors who review **Provider** claims through the claims review software system;

11. Internal and external claims and compliance audits; and

12. Any other source that identifies potential **FWA**.

III. PROCEDURE

A. Identification of **Overpayments**

1. CalOptima's SIU team shall investigate any identified **Overpayments** that are suspected to be the result of inappropriate and/or inaccurate billing activity.

2. Upon referral to CalOptima's SIU team, the SIU team shall utilize investigation software/tools to identify suspicious billing patterns, or industry-identified **FWA** trends to determine whether CalOptima disbursed an **Overpayment** to a **Provider**.

   a. Suspicious billing patterns or trends may include, but are not limited to, **Providers** who:

      i. Bill an unusually large percentage of their claims with modifiers;

      ii. Repeatedly submitting claims for procedures, items or units of services, that are excessive and/or not covered by Medi-Cal or Medicare after being advised of the error;

      iii. Submit claims for particular procedure codes at a significantly higher frequency than other **Providers** within the same specialty.

      ~~ii.~~iv. Bill a large proportion of high-level Evaluation and Management (E/M) Codes; or

      ~~iii.~~v. Prescribe an unusual amount of **Schedule II Medications** in relation to their peers.

3. During the course of an investigation, the SIU team shall review claims and/or billing activity, to either verify if services were rendered, or if services were appropriately billed, as applicable.

B. Investigation Protocol of **Overpayments**

1. During the course of an investigation, CalOptima's SIU team may identify actual or potential **Overpayments** that are suspected to be the result of inappropriate and/or inaccurate activity.

2. **FWA** investigations may identify inappropriate and inaccurate activity ~~pursuant to various activities~~through a variety of means, including but not limited to, inbound complaints, proactive data analysis, collaboration meetings with internal and external departments, and Centers for Medicaid & Medicare Services (CMS) Health Plan Management System (HPMS) ~~memorandums~~memoranda.

3. CalOptima's SIU investigation may include the following elements:

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a. Interviews with **Members**, **Providers**, and other witnesses;

b. Data analysis, including but not limited to analysis of claims billing, payment trends, and procedure code combinations, etc.;

c. Review of **Medical Records** and other records by the SIU investigator, or, for complex reviews, a clinician, such as a Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medical Doctor (MD), and Doctor of Pharmacy (Pharm. D); and

d. All relevant and pertinent data/information, as appropriate, that will aid in completing the investigation to closure.

4. The SIU shall obtain **Medical Records** and other records from the **Provider**, if it is necessary to determine if an **Overpayment** occurred.

a. The SIU shall make three (3) attempts to obtain **Medical Records** and other records from a **Provider**.

b. The number of records requested may vary depending on the nature of the investigation.

c. Records shall be submitted to the SIU within the timeframes outlined below:

i. Initial request – records must be returned within ten (10) business days.

ii. Second Request – records must be returned within four (4) business days

iii. An extension may be granted upon request and at the discretion of the SIU.

d. Failure to provide records after the final warning has been issued in writing will result in CalOptima initiating an **Overpayment** request due to the **Provider's** not being able to corroborate services rendered.

~~**Providers** must adhere to the requirements for the **Medical Record** and other records request issued by the Office of Compliance. Failure to do so may result in records not being accepted and an **Overpayment** recovery being initiated.~~

e. Providers must adhere to the requirements for the **Medical Record** and other record request set forth in the demand letter issued by the Office of Compliance.

~~**Providers** must adhere to the requirements for the **Medical Record** and other records request issued by the Office of Compliance. Failure to do so may result in records not being accepted~~

~~4.~~5. CalOptima's SIU shall consult with qualified personnel in reviewing the **Medical Records** and other records. If CalOptima's SIU investigation yields findings, and if an **Overpayment** is determined to be an appropriate administrative action that is based on potential **FWA**, inappropriate, and/or inaccurate billing, SIU shall proceed with **Overpayment** recoupment activities. SIU shall provide guidance to CalOptima Claims Administration Department, including drafting the content of **Overpayment** letters ~~and instructions for referring calls from Providers regarding FWA Overpayments to SIU.~~.

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C. Documentation

1. If SIU identifies an **Overpayment** as a result of an investigation, an "**Overpayment** Spreadsheet" shall be provided by CalOptima SIU team in detail with each determination to the Claims Administration Department.

2. The "**Overpayment** Spreadsheet" shall include the minimum necessary information to adequately review, investigate, and determine if claims were overpaid. The "**Overpayment** Spreadsheet" may include the following details, as applicable:

   a. Member name;

   b. Unique Member identification (ID) number;

   c. Claim number;

   d. HCPCS/CPT Code;

   e. ICD-9 and/or ICD-10 codes;

   f. Revenue codes;

   g. Date(s) of service;

   h. Number of services billed;

   i. Number of units allowed;

   j. Billed amount;

   k. Allowed amount;

   l. Paid amount;

   m. **Overpayment** amount; and

   n. Denial reason.

D. Resolution

1. ~~Once~~If CalOptima's SIU investigation has identified an **Overpayment**, and does not contain a component of FWA, the **Overpayment** shall be referred to CalOptima Claims Administration Department for **Overpayment** set up, collection, and recoupment, as outlined in CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. ~~CalOptima's SIU team shall review and educate Providers about billing protocols to minimize future occurrences of Overpayments.~~

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CalOptima's SIU shall notify the Department of Health Care Services (DHCS) and/or the CMS of Overpayment determinations, as required by law and state and federal regulations, in accordance with

3. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than sixty (60) calendar days after the date CalOptima identified the Overpayment.

4. When the Overpayment is the result of inappropriate and/or inaccurate billing, and contains a component of FWA, SIU shall refer such Overpayment determinations to the CalOptima Claims Administration Department for recoupment.

a. FWA overpayment determinations may be the result of FWA findings, including but not limited to:

i. Providers failing to provide appropriate documentation in the Medical Record;

ii. Improbable medical circumstances, including but not limited to, billing for services in excess of twenty-four (24) hours a day, billing for services rendered to a deceased Member, billing for three (3) hip replacements, or prescribing Acquired Immunodeficiency Syndrome (AIDS) or Hepatitis C medication to a Member with no diagnosis of such disease;

iii. Services not rendered but billed for; or

iv. Services provided after the Provider has been suspended by a licensing board or government entity.

5.2. If the claim(s) review determines that the billing was improperly paid and if the payment was determined to be based on inappropriate and/or inaccurate billing activity, and it contains a component of **FWA**, CalOptima's SIU shall:

a. Document the rationale for assessing the **Overpayment**;

b. Initiate recoupment process of the **Overpayment** through appropriate channels, including coordination with the CalOptima Claims Administration Department;

c. Send the **Provider** the required demand letter, signed by SIU staffmanagement;

d. Continue collection activity, as necessary;, and assist respective department(s) as needed with investigation in coordination with the CalOptima Claims Administration Department.;

e. Notify the DHCS and/or the CMS of **Overpayment** determinations, in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than sixty (60) calendar days after the date CalOptima identified the **Overpayment**.

6. If DHCS issues a credible allegation of Fraud as described in CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting. CalOptima shall initiate recoupment of Overpayments in according to Section III.D. of this Policy.

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~~7. If the claim(s) review determines that the billing was improperly paid and if the payment was determined to be based on inappropriate and/or inaccurate billing activity, and does not contain a component of FWA, CalOptima's Claims Administration Department shall follow up through the standard recoupment process.~~

~~IV. ATTACHMENTS~~

IV. ATTACHMENT(S)

Not Applicable

~~V. REFERENCES~~

V. REFERENCE(S)

~~A. California Health and Safety Code §1371~~
~~B.~~A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~C.~~B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D.~~A. ~~CalOptima PACE Program Agreement~~
~~E. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting~~
~~F.~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima PACE Program Agreement
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 HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
G. California Health and Safety Code §1371
~~G.~~H. CMS Guidance for Reporting Medicare Advantage Organization and/or Sponsor Identified Overpayments for CMS
~~H.~~I. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required following Notice of a Credible Allegation of Fraud
~~I.~~J. Social Security Act, §1128J(d)
~~J.~~K. Title 22, California Code of Regulations (C.C.R.), §§51045, 51047, 51458.1
~~K.~~L. Title 28, California Code of Regulations (C.C.R.), §1300.71
~~L.~~M. Title 42, Code of Federal Regulations (C.F.R.), §§405.980, 405.982, 405.984, 405.986, 405.978, 405.990, 422.326 and 423.360
~~M.~~N. Title 42, Code of Federal Regulations (C.F.R.), §§411.404, 411.406, 411.408
~~N.~~O. Title 45, Code of Federal Regulations (C.F.R.), §79
~~O.~~P. Welfare and Institutions Code, 14172, 14172.5, 14173, 14176, 14177

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

None to Date

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

~~A. 12/06/18: Regular Meeting of the CalOptima Board of Directors~~

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~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors~~
~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors~~

~~REVIEW/~~
~~**VIII.I. REVISION HISTORY**~~

Date	**Meeting**
~~**Date**~~12/07/2017	Regular Meeting of the CalOptima Board of Directors~~**Line(s) of Business**~~
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	**Date**	**Policy**	**Policy Title**	**Program(s)**
Effective	12/01/2016	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the ~~provider~~Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from ~~fraud~~Fraud, because the distinction between "~~fraud~~Fraud" and "~~abuse~~Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or ~~fraudulent~~Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)
Medical Record	A ~~medical record~~Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history.
Overpayment	For purposes of this policy, a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Schedule II Medication	Narcotic substances with a high potential for ~~abuse~~Abuse which may lead to severe psychological or physical dependence.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.5000Δ
Title:	**Provider Overpayment Investigation and Determination**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*Michael Schrader* _____
Effective Date:	12/01/2016
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

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I. PURPOSE

This policy establishes an effective system for the review of suspect claims to detect and prevent **Fraud**, **Waste**, and **Abuse** (**FWA**) within a CalOptima program, in accordance with federal and state regulations, and to identify resulting **Overpayments** for recoupment.

II. POLICY

A. The CalOptima Special Investigations Unit (SIU) shall be responsible for identifying **Overpayments** for recoupment opportunities that may emerge in the course of an **FWA** investigation.

B. During the course of an investigation, the SIU team shall review claims, review **Medical Records** and other records, and/or conduct interviews or surveys to either verify if services were rendered, or if services were appropriately billed, as applicable.

C. CalOptima may receive complaints of suspected **FWA** from any of the following sources, including but not limited to:

1. Compliance and Ethics Hotline;
2. Internal audits;
3. Internal operational reviews;
4. External audits, including audits conducted by consultants and regulatory agencies;
5. **FWA** software runs;
6. **Pharmacy Benefits Manager (PBM)**;
7. Compliance Committee;
8. Audit & Oversight Committee (AOC);
9. Internal department referrals;

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

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10. Claims auditors who review **Provider** claims through the claims review software system;

11. Internal and external claims and compliance audits; and

12. Any other source that identifies potential **FWA**.

III. PROCEDURE

A. Identification of **Overpayments**

1. CalOptima's SIU team shall investigate any identified **Overpayments** that are suspected to be the result of inappropriate and/or inaccurate billing activity.

2. Upon referral to CalOptima's SIU team, the SIU team shall utilize investigation software/tools to identify suspicious billing patterns, or industry-identified **FWA** trends to determine whether CalOptima disbursed an **Overpayment** to a **Provider**.

   a. Suspicious billing patterns or trends may include, but are not limited to, **Providers** who:

      i. Bill an unusually large percentage of their claims with modifiers;

      ii. Repeatedly submitting claims for procedures, items or units of services, that are excessive and/or not covered by Medi-Cal or Medicare after being advised of the error;

      iii. Submit claims for particular procedure codes at a significantly higher frequency than other **Providers** within the same specialty.

      iv. Bill a large proportion of high-level Evaluation and Management (E/M) Codes; or

      v. Prescribe an unusual amount of **Schedule II Medications** in relation to their peers.

3. During the course of an investigation, the SIU team shall review claims and/or billing activity, to either verify if services were rendered, or if services were appropriately billed, as applicable.

B. Investigation Protocol of **Overpayments**

1. During the course of an investigation, CalOptima's SIU team may identify actual or potential **Overpayments** that are suspected to be the result of inappropriate and/or inaccurate activity.

2. **FWA** investigations may identify inappropriate and inaccurate activity through a variety of means, including but not limited to, inbound complaints, proactive data analysis, collaboration meetings with internal and external departments, and Centers for Medicaid & Medicare Services (CMS) Health Plan Management System (HPMS) memoranda.

3. CalOptima's SIU investigation may include the following elements:

   a. Interviews with **Members**, **Providers**, and other witnesses;

   b. Data analysis, including but not limited to analysis of claims billing, payment trends, and procedure code combinations, etc.;

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c. Review of **Medical Records** and other records by the SIU investigator, or, for complex reviews, a clinician, such as a Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medical Doctor (MD), and Doctor of Pharmacy (Pharm. D); and

d. All relevant and pertinent data/information, as appropriate, that will aid in completing the investigation to closure.

4. The SIU shall obtain **Medical Records** and other records from the **Provider**, if it is necessary to determine if an **Overpayment** occurred.

a. The SIU shall make three (3) attempts to obtain **Medical Records** and other records from a **Provider**.

b. The number of records requested may vary depending on the nature of the investigation.

c. Records shall be submitted to the SIU within the timeframes outlined below:

i. Initial request – records must be returned within ten (10) business days.

ii. Second Request – records must be returned within four (4) business days

iii. An extension may be granted upon request and at the discretion of the SIU.

d. Failure to provide records after the final warning has been issued in writing will result in CalOptima initiating an **Overpayment** request due to the **Provider's** not being able to corroborate services rendered.

~~**Providers** must adhere to the requirements for the **Medical Record** and other records request issued by the Office of Compliance. Failure to do so may result in records not being accepted and an **Overpayment** recovery being initiated.~~

e. Providers must adhere to the requirements for the **Medical Record** and other record request set forth in the demand letter issued by the Office of Compliance.

~~**Providers** must adhere to the requirements for the **Medical Record** and other records request issued by the Office of Compliance. Failure to do so may result in records not being accepted~~

5. CalOptima's SIU shall consult with qualified personnel in reviewing the **Medical Records** and other records. If CalOptima's SIU investigation yields findings, and if an **Overpayment** is determined to be an appropriate administrative action that is based on potential **FWA**, inappropriate, and/or inaccurate billing, SIU shall proceed with **Overpayment** recoupment activities. SIU shall provide guidance to CalOptima Claims Administration Department, including drafting the content of **Overpayment** letters.

C. Documentation

1. If SIU identifies an **Overpayment** as a result of an investigation, an "**Overpayment** Spreadsheet" shall be provided by CalOptima SIU team in detail with each determination to the Claims Administration Department.

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2. The "**Overpayment** Spreadsheet" shall include the minimum necessary information to adequately review, investigate, and determine if claims were overpaid. The "**Overpayment** Spreadsheet" may include the following details, as applicable:

    a. Member name;

    b. Unique Member identification (ID) number;

    c. Claim number;

    d. HCPCS/CPT Code;

    e. ICD-9 and/or ICD-10 codes;

    f. Revenue codes;

    g. Date(s) of service;

    h. Number of services billed;

    i. Number of units allowed;

    j. Billed amount;

    k. Allowed amount;

    l. Paid amount;

    m. **Overpayment** amount; and

    n. Denial reason.

D. Resolution

1. If CalOptima's SIU investigation has identified an **Overpayment**, and does not contain a component of FWA, the **Overpayment** shall be referred to CalOptima Claims Administration Department for **Overpayment** set up, collection, and recoupment, as outlined in CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. If the claim(s) review determines that the billing was improperly paid and if the payment was determined to be based on inappropriate and/or inaccurate billing activity, and it contains a component of **FWA**, CalOptima's SIU shall:

    a. Document the rationale for assessing the **Overpayment**;

    b. Initiate recoupment process of the **Overpayment** through appropriate channels, including coordination with the CalOptima Claims Administration Department;

    c. Send the **Provider** the required demand letter, signed by SIU management;

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d. Continue collection activity, as necessary, and assist respective department(s) as needed with investigation in coordination with the CalOptima Claims Administration Department;

e. Notify the DHCS and/or the CMS of **Overpayment** determinations, in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than sixty (60) calendar days after the date CalOptima identified the **Overpayment**.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima PACE Program Agreement
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 HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
G. California Health and Safety Code §1371
H. CMS Guidance for Reporting Medicare Advantage Organization and/or Sponsor Identified Overpayments for CMS
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required following Notice of a Credible Allegation of Fraud
J. Social Security Act, §1128J(d)
K. Title 22, California Code of Regulations (C.C.R.), §§51045, 51047, 51458.1
L. Title 28, California Code of Regulations (C.C.R.), §1300.71
M. Title 42, Code of Federal Regulations (C.F.R.), §§405.980, 405.982, 405.984, 405.986, 405.978, 405.990, 422.326 and 423.360
N. Title 42, Code of Federal Regulations (C.F.R.), §§411.404, 411.406, 411.408
O. Title 45, Code of Federal Regulations (C.F.R.), §79
P. Welfare and Institutions Code, 14172, 14172.5, 14173, 14176, 14177

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

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Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)
Medical Record	A Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history.
Overpayment	For purposes of this policy, a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Schedule II Medication	Narcotic substances with a high potential for Abuse which may lead to severe psychological or physical dependence.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

FOR 2019 2ND BOD REVIEW

Policy ~~#:~~:	HH.3001Δ
Title:	**Member Access to Designated Record Set**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*Michael Schrader* _____
Effective Date:	04/01/~~03~~2003
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~

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

~~*Board Approved Policy*~~

FOR 20191205BOD REVIEW

I. PURPOSE

This policy defines the **Designated Record Set (DRS)** that contains **Protected Health Information (PHI)** for a **Member**, maintained by CalOptima and the conditions under which the **Member**, or their Personal Representative, may access, inspect, or obtain a copy of ~~his or her~~their **PHI** in the **DRS**.

II. POLICY

A. Except as otherwise provided in Section III.A.9 of this Policy, **Members** shall have the right of access to inspect and obtain a copy of their **PHI** in the **DRS** for as long as CalOptima maintains the **PHI** in the **DRS**.

~~1. Records are retained in accordance with CalOptima Policy HH.2022Δ: Record Retention and Access.~~

B. CalOptima shall provide a **Member** with access to their **PHI** in the format requested by the **Member**, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by CalOptima and the **Member**.

~~C. If the Member requests their PHI to be sent via mail, CalOptima may impose a reasonable, cost-based fee for postage.~~

~~D.~~C. CalOptima shall grant a **Member's** ~~Authorized~~Personal Representative access to a **Member's PHI**, in accordance with CalOptima Policies HH.3009Δ: Access by **Member's** Personal Representative and HH.3015Δ: Member Authorization for the Use and Disclosure of Protected Health Information.

~~E.~~D. Any person with knowledge of a violation, or potential violation, of this Policy shall report such information to the Privacy Officer directly, or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417 or email: ~~privacy@caloptima.org.~~privacy@caloptima.org.

III. PROCEDURE

A. Requests for access to inspect or obtain a copy of **DRS**:

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1. A **Member** shall submit a written request for access to inspect or obtain a copy of ~~his or her~~their **PHI** in the **DRS** by submitting the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form to the Office of Compliance. A **Member's** Personal Representative may request access to the **Member's PHI** in accordance with the requirements set forth in CalOptima Policy HH.3009Δ: Access by Member's ~~Personal~~Authorized Representative~~.~~.

   a. ~~The DRS does not include~~**Member** or their **Personal Representative** has the right to direct CalOptima to transmit the **PHI** directly to another person, or entity, as designated by the **Member** or their **Personal Representative**, in accordance with CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative.

      i. The **Member's** or their **Personal Representative's** request to transmit the **PHI** to another person, or entity, must be in writing, signed by the **Member** or their **Personal Representative,** and clearly identify the designated person, or entity, and location (postal address) to send the **PHI**.

2. While CalOptima's **DRS** contains certain medical and payment records from providers, it does not have complete copies of records created and/or maintained by **Providers** or entities other than CalOptima. If a **Member** wants such records, they are advised to contact their doctor, **Health Network**, or other health care ~~provider.~~**Provider**. CalOptima does maintain medical and billing records for PACE Program participants which may be obtained by the Participant or their Personal Representative."

3. CalOptima shall process a request to access, inspect or obtain copies of the PHI in the DRS ~~within~~promptly, and unless an extension is required under Section III.A.4., no later than thirty (30) calendar days after receipt of a complete written request.

   a. If the **Member** requests their **PHI** to be sent via mail, CalOptima may impose a reasonable, cost- based fee for postage and may charge up to ten cents ($0.10) per page.

~~3.~~4. If necessary, a thirty (30) calendar day extension may be used to retrieve information that is not readily available.

   a. For an extension, CalOptima must provide the **Member**, within thirty (30) calendar days after receipt of the request, a written statement of the reasons for the delay and the date by which it will complete its action on the request.

   b. CalOptima may only have one (1) such extension of time for action on a request for access to **DRS**.

~~4.~~5. The Office of Compliance shall notify the **Member**, in writing, of the determination on the request. The notice shall contain the information set forth in Section III.E. of this Policy.

~~5.~~6. Verification of **Member** identification requesting access to inspect or copy the **DRS**:

   a. If the **Member** makes such request in person to the Customer Service Department, Customer Service staff shall:

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i. Request identification (e.g., Driver License or **Member** ID card), or ask to verify the **Member's** date of birth or address based on **FACETS™** data; and

ii. Provide the **Member** with a copy of the Individual Request for Access to Protected Health Information (PHI) Contained in the DRS Form for the **Member** to complete.

b. If the **Member** request is received by mail or fax, the Office of Compliance staff shall verify the identity of the individual in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for **Disclosure** of **Protected Health Information**.

~~6.~~7. The Office of Compliance shall accept ~~the~~a request from the **Member** as valid, provided all information on the request is complete and accurate. All requests shall include~~, as applicable:~~:

~~a. An Authorization for Release of Protected Health Information Form, as applicable, for Disclosure of a Member's PHI to a third party;~~

~~b.~~a. An Individual Request for Access to **Protected Health Information (PHI)** Contained in the **DRS** Form; or

~~c.~~b. A written request that provides sufficient information, as necessary to identify the specific **PHI** sought; and

~~d.~~c. Documentation that verifies the identity of the **Member**, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for **Disclosure** of **Protected Health Information**.

~~7.~~8. The Office of Compliance shall review the request, determine if **Member** access is appropriate, and which parts of the **DRS** the **Member** cannot access.

~~8.~~9. The Office of Compliance ~~shall~~may deny **Member** access in the following circumstances:

~~a. PHI that is not part of a DRS because the information is not used to make decisions about Members;~~

~~b.~~a. **Psychotherapy Notes**;

~~c.~~b. **PHI** compiled in reasonable anticipation of, or for ~~use~~**Use** in, a civil, criminal, or administrative action, or proceeding;

~~d.~~c. A CalOptima PACE covered health care ~~provider~~**Provider** acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to obtain a copy of **PHI**, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting of the inmate;

~~e.~~d. A **Member's** access to **PHI** created or obtained by a CalOptima PACE covered health care ~~provider~~**Provider** in the course of research that includes ~~treatment~~**Treatment** may be temporarily suspended for as long as the research is in progress, provided that the **Member**

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has agreed to the denial of access when consenting to participate in the research that includes ~~treatment~~**Treatment**, and the covered health care ~~provider~~**Provider** has informed the **Member** that the right of access will be reinstated upon completion of the research;

~~f.~~e. With respect to CalOptima OneCare Connect Program, a **Member's** access to **PHI** that is contained in records that are subject to the Privacy Act, 5 USC § 552a, may be denied, if the denial of access under the Privacy Act would meet the requirements of that law;

~~g.~~f. **PHI** obtained from someone other than a **Provider** under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information.

~~h.~~g. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life, or physical safety, of the **Member**, or another person;

~~f~~h. The **PHI** makes reference to another person other than the **Member**, unless that person is a **Provider**, and a licensed health care professional has determined, in his or her professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

~~g~~i. The **Personal Representative** requests for access, and a licensed health care professional has determined, in ~~his or her~~their professional judgment, that the provision of access to such **Personal Representative** is reasonably likely to cause substantial harm to the individual, or another person.

~~9.~~10. If the denial is based on any of the reasons as stated in Section III.A.9 ~~h – j.,~~g- i, a **Member** can request to have the denial reviewed by another licensed health care professional by submitting a written request to the CalOptima Privacy Officer at 505 City Parkway West, Orange, CA 92868. The licensed health care professional involved in the appeal cannot be the same person as the licensed health care professional who made the original denial decision.

11. If the denial is based on any of the reasons as stated in Section III.A.9 a-f, a **Member** is not entitled to request that the denial be reviewed.

~~10.~~12. The Office of Compliance shall route the request to the department(s), or ~~Business Associate~~business associate responsible for creating, or maintaining, the requested record(s).

13. The responsible department shall locate and send a copy of ~~the~~all requested **PHI** to the Office of Compliance within seven (7) calendar days of receiving the request.

14. The Business Associate shall send a copy of the requested **PHI** to the Office of Compliance within fourteen (14) calendar days of receiving the request.

15. The Office of Compliance shall review all records for accuracy prior to providing the requested records to the **Member** or their **Personal Representative**.

B. The following departments within CalOptima shall ~~have responsibility for~~ maintain the content found in the **DRS**:

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1. Customer Service;

2. Information Systems;

3. Claims Administration;

4. Utilization Management;

5. Case Management;

6. Pharmacy;

7. Grievance and Appeals Resolution Services;

8. Enrollment;

9. **Multipurpose Senior Services Program (MSSP)**;

10. **Long- Term Services and Supports (LTSS)**;

11. Population Health ~~Education and Disease~~ Management; ~~and~~

12. Behavioral Health~~.~~; and

13. Program of All-Inclusive Care for the Elderly (PACE).

C. Department staff shall ~~consult~~ provide copies of all requested PHI. Department staff shall inform the Privacy Officer if there ~~is any doubt about the~~are records that require further evaluation to determine appropriateness of Member access to inspect or copy PHI from the DRS.

D. The Privacy Officer shall consult with a licensed healthcare professional to determine appropriateness of **Member** access to inspect or copy **PHI** from the **DRS**.

1. Access to specific types of records may be denied based on the determination of the licensed healthcare professional, as provided by the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

~~D.~~E. If CalOptima does not maintain the **PHI** that is the subject of the **Member's** request for access, and CalOptima knows where the requested information is maintained, CalOptima shall inform the **Member** of the entity to whom the **Member** may direct such request.

~~E.~~F. Notification to **Member**:

1. The Office of Compliance shall notify the **Member** regarding the record request as follows:

   a. Approved: If CalOptima approves the **Member's** request, CalOptima shall provide the **Member** with a notification letter (Attachment H. Letter – Records Enclosed) and the records requested, in accordance with the format and method designated on the Individual Request for Access to **Protected Health Information (PHI)** Contained in the **Designated Record**

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Set Form within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed.

b. Denied: If CalOptima denies the **Member's** request, CalOptima shall send a notification letter to the **Member** within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed, informing the **Member** of the decision, the reason for denial, and instructions on **Member's** appeal rights to have the materials reviewed, if applicable. The denial notice shall include a description of how a **Member** may complain to CalOptima, or the Office of Civil Rights (OCR), and contact information for how to file a complaint with CalOptima.

c. Approved or denied, in whole or in part: If CalOptima approves a portion of the **Member's** request and also denies portion of the request, CalOptima shall provide the **Member** with the records requested in accordance with Section III.~~E~~F.1.a of this Policy. CalOptima shall also provide a letter informing the **Member** of the denial, in accordance with Section III.~~E~~F.1.b of this Policy~~.~~.

d. Invalid Request: If the request is unable to be processed due to missing information, CalOptima will notify the **Member** or their Personal Representatives with a letter (Attachment G – Invalid Request) as soon as possible but no later than within thirty (30) calendar days of receipt.

~~F.~~G. Documentation

1. The Office of Compliance shall retain a record of the requests and related letters, including a copy of information released to the **Member**, for ten (10) years from the date of the release.

~~G.~~H. **Designated Record Set** Content

1. The content of CalOptima's **DRS** can be found in the **Designated Record Set** Matrix (Attachment A)

IV. ATTACHMENTS

A. Designated Record Set Matrix
~~B. Authorization for Release of Protected Health Information (PHI)~~
B. ~~Individual~~ Instruction Sheet for CalOptima Health Insurance Portability and Accountability Act (HIPAA) Authorization for Release of Protected Health Information
C. Form~~:~~ Authorization for Release of Protected Health Information (PHI)
D. Form: Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS)
E. Letter: Denial of Access-Subject to ~~review~~Review
F. Letter: Denial of Access-Not Subject to ~~review~~Review
G. Letter: Request Invalid
H. Letter: Records Enclosed

V. REFERENCES

A. CalOptima Compliance Plan

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B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Notice of Privacy Practices
F. CalOptima Policy HH.2022Δ: Record Retention and Access
G. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
H. CalOptima Policy HH.3004Δ: Member Request to Amend Records
I. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative
J. CalOptima Policy HH.3015Δ: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
K. CalOptima Privacy Program
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
M. NCQA Standard MED5 Privacy and Confidentiality: Element A: Factor 2 – 2017
N. Title 45, Code of Federal Regulations (C.F.R.), §164.501
O. Title 45, Code of Federal Regulations (C.F.R.), §164.524
P. Title 45, Code of Federal Regulations (C.F.R.), §164.530(j)(2)

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

None to Date

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

~~A. 12/06/18: Regular Meeting of the CalOptima Board of Directors~~
~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors~~
~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors~~

~~REVIEW/~~
~~VIII.I. REVISION HISTORY~~

Date	Meeting
~~Date~~12/06/2018	Regular Meeting of the CalOptima Board of Directors~~Line(s) of Business~~
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3001	Member Access to Designated Record Set	Medi-Cal
Effective	08/01/2005	MA.9203	Member Access to Designated Record Set	OneCare
Revised	04/01/2007	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2008	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2008	MA.9203	Member Access to Designated Record Set	OneCare
Revised	07/01/2011	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2011	MA.9203	Member Access to Designated Record Set	OneCare

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Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2013	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	06/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	11/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	11/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	09/01/2015	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2015	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	05/01/2017	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative 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 and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.

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Term	Definition
Business AssociateDesignated Record Set (DRS)	Has the meaning given such term in Section 160.103164.501 of Title 45, Code of Federal Regulations. A person or entity who: On behalfA group of such records maintained by or for a covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; orthat is: 1. The medical records and billing records about individuals maintained by or for a covered health care Provider; 2. The enrollment, Payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. 1. The term record means any item, collection, or grouping of information that Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information toand is maintained, collected, Used, or disseminated by or for a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

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Term	Definition
~~Designated Record Set~~	~~Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is:~~ ~~1. The medical records and billing records about individuals maintained by or for a covered health care provider;~~ ~~2.~~1.~~The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or~~ ~~3.~~1.~~Used, in whole or in part, by or for the covered entity to make decisions about individuals.~~ ~~The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.~~
Disclosure	Has the meaning in Title 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, ~~membership~~Membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; and 3. Skilled nursing facility services and subacute care services.
Member	An enrollee-beneficiary of a CalOptima program.
Multipurpose Senior Services Program (MSSP)	A program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

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Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Personal Representative	Has the meaning given to the term Personal Representative 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 and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Protected Health Information (PHI)	Has the meaning in Title 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 or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary ~~provider~~Provider, health maintenance organization, or other person or institution that furnishes Covered Services.

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Term	Definition
Psychotherapy Notes	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. Notes recorded (in any medium) by a health care ~~provider~~Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the Member's medical record. Psychotherapy ~~notes~~Notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of ~~treatment~~Treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the ~~treatment~~Treatment plan, symptoms, prognosis, and progress to date
Treatment	Has the meaning in ~~42~~45 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care ~~providers~~Providers; and coordination with third parties for services related to the management of the ~~Member's~~Member's health care benefits.
Use	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3001Δ
Title:	**Member Access to Designated Record Set**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*Michael Schrader* _____
Effective Date:	04/01/2003
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

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I. PURPOSE

This policy defines the **Designated Record Set (DRS)** that contains **Protected Health Information (PHI)** for a **Member**, maintained by CalOptima and the conditions under which the **Member**, or their Personal Representative, may access, inspect, or obtain a copy of their **PHI** in the **DRS**.

II. POLICY

A. Except as otherwise provided in Section III.A.9 of this Policy, **Members** shall have the right of access to inspect and obtain a copy of their **PHI** in the **DRS** for as long as CalOptima maintains the **PHI** in the **DRS**.

B. CalOptima shall provide a **Member** with access to their **PHI** in the format requested by the **Member**, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by CalOptima and the **Member**.

C. CalOptima shall grant a **Member's** Personal Representative access to a **Member's PHI**, in accordance with CalOptima Policies HH.3009Δ: Access by **Member's** Personal Representative and HH.3015Δ: Member Authorization for the Use and Disclosure of Protected Health Information.

D. Any person with knowledge of a violation, or potential violation, of this Policy shall report such information to the Privacy Officer directly, or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417 or email: privacy@caloptima.org.

III. PROCEDURE

A. Requests for access to inspect or obtain a copy of **DRS**:

1. A **Member** shall submit a written request for access to inspect or obtain a copy of their **PHI** in the **DRS** by submitting the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form to the Office of Compliance. A **Member's** Personal Representative may request access to the **Member's PHI** in accordance with the requirements set forth in CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative.

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a. **Member** or their **Personal Representative** has the right to direct CalOptima to transmit the **PHI** directly to another person, or entity, as designated by the **Member** or their **Personal Representative**, in accordance with CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative.

i. The **Member's** or their **Personal Representative's** request to transmit the **PHI** to another person, or entity, must be in writing, signed by the **Member** or their **Personal Representative,** and clearly identify the designated person, or entity, and location (postal address) to send the **PHI**.

2. While CalOptima's **DRS** contains certain medical and payment records from providers, it does not have complete copies of records created and/or maintained by **Providers** or entities other than CalOptima. If a **Member** wants such records, they are advised to contact their doctor, **Health Network**, or other health care **Provider**. CalOptima does maintain medical and billing records for PACE Program participants which may be obtained by the Participant or their Personal Representative."

3. CalOptima shall process a request to access, inspect or obtain copies of the PHI in the DRS promptly, and unless an extension is required under Section III.A.4., no later than thirty (30) calendar days after receipt of a complete written request.

a. If the **Member** requests their **PHI** to be sent via mail, CalOptima may impose a reasonable, cost- based fee for postage and may charge up to ten cents ($0.10) per page.

4. If necessary, a thirty (30) calendar day extension may be used to retrieve information that is not readily available.

a. For an extension, CalOptima must provide the **Member**, within thirty (30) calendar days after receipt of the request, a written statement of the reasons for the delay and the date by which it will complete its action on the request.

b. CalOptima may only have one (1) such extension of time for action on a request for access to **DRS**.

5. The Office of Compliance shall notify the **Member**, in writing, of the determination on the request. The notice shall contain the information set forth in Section III.E. of this Policy.

6. Verification of **Member** identification requesting access to inspect or copy the **DRS**:

a. If the **Member** makes such request in person to the Customer Service Department, Customer Service staff shall:

i. Request identification (e.g., Driver License or **Member** ID card), or ask to verify the **Member's** date of birth or address based on **FACETS™** data; and

ii. Provide the **Member** with a copy of the Individual Request for Access to Protected Health Information (PHI) Contained in the DRS Form for the **Member** to complete.

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b. If the **Member** request is received by mail or fax, the Office of Compliance staff shall verify the identity of the individual in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for **Disclosure** of **Protected Health Information**.

7. The Office of Compliance shall accept a request from the **Member** as valid, provided all information on the request is complete and accurate. All requests shall include:

   a. An Individual Request for Access to **Protected Health Information (PHI)** Contained in the **DRS** Form; or

   b. A written request that provides sufficient information, as necessary to identify the specific **PHI** sought; and

   c. Documentation that verifies the identity of the **Member**, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for **Disclosure** of **Protected Health Information**.

8. The Office of Compliance shall review the request, determine if **Member** access is appropriate, and which parts of the **DRS** the **Member** cannot access.

9. The Office of Compliance may deny **Member** access in the following circumstances:

   a. **Psychotherapy Notes**;

   b. **PHI** compiled in reasonable anticipation of, or for **Use** in, a civil, criminal, or administrative action, or proceeding;

   c. A CalOptima PACE covered health care **Provider** acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to obtain a copy of **PHI**, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting of the inmate;

   d. A **Member's** access to **PHI** created or obtained by a CalOptima PACE covered health care **Provider** in the course of research that includes **Treatment** may be temporarily suspended for as long as the research is in progress, provided that the **Member** has agreed to the denial of access when consenting to participate in the research that includes **Treatment**, and the covered health care **Provider** has informed the **Member** that the right of access will be reinstated upon completion of the research;

   e. With respect to CalOptima OneCare Connect Program, a **Member's** access to **PHI** that is contained in records that are subject to the Privacy Act, 5 USC § 552a, may be denied, if the denial of access under the Privacy Act would meet the requirements of that law;

   f. **PHI** obtained from someone other than a **Provider** under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information.

   g. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life, or physical safety, of the **Member**, or another person;

   h. The **PHI** makes reference to another person other than the **Member**, unless that person is a **Provider**, and a licensed health care professional has determined, in his or her professional

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judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

i. The **Personal Representative** requests for access, and a licensed health care professional has determined, in their professional judgment, that the provision of access to such **Personal Representative** is reasonably likely to cause substantial harm to the individual, or another person.

10. If the denial is based on any of the reasons as stated in Section III.A.9 g- i, a **Member** can request to have the denial reviewed by another licensed health care professional by submitting a written request to the CalOptima Privacy Officer at 505 City Parkway West, Orange, CA 92868. The licensed health care professional involved in the appeal cannot be the same person as the licensed health care professional who made the original denial decision.

11. If the denial is based on any of the reasons as stated in Section III.A.9 a-f, a **Member** is not entitled to request that the denial be reviewed.

12. The Office of Compliance shall route the request to the department(s), or business associate responsible for creating, or maintaining, the requested record(s).

13. The responsible department shall locate and send a copy of all requested **PHI** to the Office of Compliance within seven (7) calendar days of receiving the request.

14. The Business Associate shall send a copy of the requested **PHI** to the Office of Compliance within fourteen (14) calendar days of receiving the request.

15. The Office of Compliance shall review all records for accuracy prior to providing the requested records to the **Member** or their **Personal Representative**.

B. The following departments within CalOptima shall maintain the content found in the **DRS**:

1. Customer Service;
2. Information Systems;
3. Claims Administration;
4. Utilization Management;
5. Case Management;
6. Pharmacy;
7. Grievance and Appeals Resolution Services;
8. Enrollment;
9. **Multipurpose Senior Services Program (MSSP)**;
10. **Long-Term Services and Supports (LTSS)**;
11. Population Health Management;

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12. Behavioral Health; and

13. Program of All-Inclusive Care for the Elderly (PACE).

C. Department staff shall provide copies of all requested PHI. Department staff shall inform the Privacy Officer if there are records that require further evaluation to determine appropriateness of Member access to inspect or copy PHI from the DRS.

D. The Privacy Officer shall consult with a licensed healthcare professional to determine appropriateness of **Member** access to inspect or copy **PHI** from the **DRS**.

1. Access to specific types of records may be denied based on the determination of the licensed healthcare professional, as provided by the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

E. If CalOptima does not maintain the **PHI** that is the subject of the **Member's** request for access, and CalOptima knows where the requested information is maintained, CalOptima shall inform the **Member** of the entity to whom the **Member** may direct such request.

F. Notification to **Member**:

1. The Office of Compliance shall notify the **Member** regarding the record request as follows:

a. Approved: If CalOptima approves the **Member's** request, CalOptima shall provide the **Member** with a notification letter (Attachment H. Letter – Records Enclosed) and the records requested, in accordance with the format and method designated on the Individual Request for Access to **Protected Health Information (PHI)** Contained in the **Designated Record Set** Form within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed.

b. Denied: If CalOptima denies the **Member's** request, CalOptima shall send a notification letter to the **Member** within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed, informing the **Member** of the decision, the reason for denial, and instructions on **Member's** appeal rights to have the materials reviewed, if applicable. The denial notice shall include a description of how a **Member** may complain to CalOptima, or the Office of Civil Rights (OCR), and contact information for how to file a complaint with CalOptima.

c. Approved or denied, in whole or in part: If CalOptima approves a portion of the **Member's** request and also denies portion of the request, CalOptima shall provide the **Member** with the records requested in accordance with Section III.F.1.a of this Policy. CalOptima shall also provide a letter informing the **Member** of the denial, in accordance with Section III.F.1.b of this Policy.

d. Invalid Request: If the request is unable to be processed due to missing information, CalOptima will notify the **Member** or their Personal Representatives with a letter (Attachment G – Invalid Request) as soon as possible but no later than within thirty (30) calendar days of receipt.

G. Documentation

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1. The Office of Compliance shall retain a record of the requests and related letters, including a copy of information released to the **Member**, for ten (10) years from the date of the release.

H. **Designated Record Set** Content

1. The content of CalOptima's **DRS** can be found in the **Designated Record Set** Matrix (Attachment A)

IV. ATTACHMENTS

A. Designated Record Set Matrix
B. Instruction Sheet for CalOptima Health Insurance Portability and Accountability Act (HIPAA) Authorization for Release of Protected Health Information
C. Form: Authorization for Release of Protected Health Information (PHI)
D. Form: Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS)
E. Letter: Denial of Access-Subject to Review
F. Letter: Denial of Access-Not Subject to Review
G. Letter: Request Invalid
H. Letter: Records Enclosed

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Notice of Privacy Practices
F. CalOptima Policy HH.2022Δ: Record Retention and Access
G. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
H. CalOptima Policy HH.3004Δ: Member Request to Amend Records
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J. CalOptima Policy HH.3015Δ: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
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N. Title 45, Code of Federal Regulations (C.F.R.), §164.501
O. Title 45, Code of Federal Regulations (C.F.R.), §164.524
P. Title 45, Code of Federal Regulations (C.F.R.), §164.530(j)(2)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/06/2018	Regular Meeting of the CalOptima Board of Directors

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Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3001	Member Access to Designated Record Set	Medi-Cal
Effective	08/01/2005	MA.9203	Member Access to Designated Record Set	OneCare
Revised	04/01/2007	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2008	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2008	MA.9203	Member Access to Designated Record Set	OneCare
Revised	07/01/2011	HH.3001	Member Access to Designated Record Set	Medi-Cal
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Revised	01/01/2013	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	06/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	11/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	11/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	09/01/2015	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2015	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	05/01/2017	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised		HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care Provider; 2. The enrollment, Payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, Used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in Title 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, Membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; and 3. Skilled nursing facility services and subacute care services.
Member	An enrollee-beneficiary of a CalOptima program.
Multipurpose Senior Services Program (MSSP)	A program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

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Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Personal Representative	Has the meaning given to the term Personal Representative 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 and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Protected Health Information (PHI)	Has the meaning in Title 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 or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, 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.
Psychotherapy Notes	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. Notes recorded (in any medium) by a health care Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the Member's medical record. Psychotherapy Notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of Treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the Treatment plan, symptoms, prognosis, and progress to date

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Term	Definition
Treatment	Has the meaning in 45 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Designated Record Set Matrix		
DRS Content	**Source**	**Media Type For Member**
(1) Enrollment Form from Member (CalOptima does not maintain such forms for Medi-Cal Members)	Customer Service	Enrollment Form (signed)
(2) Auto-Assignment and Health Network changes	Customer Service	Print out/report from FACETS™ of health network changes
(3) Eligibility Records	Customer Service	Screenshot of member eligibility history
(4) Customer Service Task Notes	Customer Service	CORE Report
(5) Claims Records (Medical and Pharmacy Claims)	Claims	Health Insurance Claim Forms, Remittance Advices, documentation submitted with claim forms
	Pharmacy	CalOptima Pharmacy Claims CORE Report
(6) Prior, current and retrospective Authorization Records (ARF/PA request and attachments, Notice of Action (NOA) letters)	Utilization Management	Authorization and denial letters from GuidingCare and/ or Summary report from CCMS system
(7) Prior, current and retrospective Authorization Records (Pharmacy)	Pharmacy	Authorization and denial letters from Pharmacy Benefit Manager (PBM) files GuidingCare and/ or Summary report from CCMS system
(8) Grievance and Appeals Resolution letters State Hearing Letters	GARS	**Grievance File** Acknowledgement Letter Resolution Letter Complaint Referral Forms Cae Notes If any medical records are obtained **Appeal File** Acknowledgement Letter Resolution Letter Medical Records Notice of Action State Hearing Records 14 day extension letter, if applicable Print out/report from Guiding Care and/or GARS database
(9) Prior Authorization Records Care Plans and Assessments	MSSP	Print out/report from Guiding Care and/or MSSP database
	LTSS	Print out/report from Guiding Care and/or LTSS database
	LTC	Print out/report from Guiding Care and/or LTC database
(10) Care Plan Records, Assessments and Notes	Health Education and Disease Management	Print out/report from GuidingCare and/or Health Education and Disease Management Database
(11) Behavioral Health Authorizations and Denials Care Management Notes	Behavioral Health	Print out/report from GuidingCare
(12) Entries in Care Management Data Systems including contacts with Member or other coordination activities used in making decisions about the Member	Case Management	Paper copy Summary reports from clinical systems and data base files
(13) Durable Medical Equipment (DME) Assessments	MSSP/ Utilization Management	Paper copy from clinical systems and data base files
Employment records held by CalOptima in its role as an employer are not PHI and therefore are not subject to the HIPAA Privacy Rule. In addition, a Member does not have a right of access to PHI that is not part of a Designated Record Set (DRS) because the information is not used to make a decision about Members. Examples include: quality assurance records, accrediation reports, statistical reports (and any related internal department notes and call recordings).		

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Fill out **ALL** sections of this form to allow CalOptima to release your protected health information (PHI) to another person or agency. This form is **ONLY** to release the information. It will not allow anyone to make health care decisions for you.

SECTION A: Member Information

Last Name: _____ First Name: _____

CIN: _____ Date of Birth: _____ *mm/dd/yyyy*

Address: _____

Street/Unit Number *City* *State* *Zip Code*

Best phone number to contact you: _____

Instructions: Mark X inside the box next to your selected option.

SECTION B: Information That Can Be Released

I allow CalOptima to release:

☐ Any and all of my PHI

☐ Only release the following: (list what you allow):

_____

_____

I allow the release of PHI about:
(Initial if any of the below boxes are checked)

☐ Mental health treatment Initial:_____
☐ Alcohol / drug treatment Initial:_____

NOTE: These details will not be released unless you approve first.

SECTION C: Purpose of Authorization

I am releasing this information for:

☐ Personal Use ☐ Legal

☐ Insurance ☐ Other (please specify.): _____

SECTION D: Person(s) or Agency Allowed to Get PHI

I allow CalOptima to release my PHI to the person or agency below. I know this authorization starts when I sign and return this form. The person getting the information must be 18 years of age or older.

Person /Agency's Name(s): _____

Relationship to Member: _____ Phone: _____

SECTION E: My Rights

- I may stop this authorization at any time by sending a **written** notice to: CalOptima, Attn: Enrollment & Reconciliation, 505 City Parkway West, Orange, CA 92868.
- Notice to stop this authorization will not change how CalOptima used or released my PHI before getting my letter.
- The person or agency who gets my PHI from CalOptima may show it to others. In this case, my PHI may no longer be protected by HIPAA Privacy Rules.
- I do not have to fill out this form. Not filling out this form will not change my health care benefits or payment for my health care services.
- I have the right to look at or get a copy of my PHI that is being used or released by this authorization.
- I have the right to get a copy of this form.

SECTION F: End Date of Approval

This authorization for release of information to the named persons or agency will end on: _____ (specific date or event).

**** If an end date or event is not provided, the authorization will not be valid. ****

SECTION G: Signature

I understand that to process my request, a copy of valid government-issued identification (ID), a copy of documentation of legal authority, or a notarized signature must be attached with my request form.

By signing below, I have read this form and know what it means.

_____ _____

Signature of Member/Personal Representative Date

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

CalOptima reserves the right to request legal documentation (e.g., birth certificate, court order, etc.) from the parent/guardian signing on behalf of a dependent member.

Personal Representatives Only: What rights do you have to request health information?

Print Name: _____

- ☐ Conservator
- ☐ Executor of Will
- ☐ Administrator of Estate
- ☐ Medical Power of Attorney
- ☐ Other_____

NOTE: You must attach legal documentation to verify that you are the conservator, executor of a decedent's will, or have medical decision-making authority for the individual.

Please mail this form to CalOptima, Attn: Enrollment & Reconciliation, 505 City Parkway West, Orange CA 92868, or fax it to **1-714-338-3104**.

STOP

For CalOptima Use Only:

Staff Name: _____ How was identity verified? In person/Phone

Signature: Date verified:

INSTRUCTION SHEET FOR CALOPTIMA HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or organization. Please complete all items of information in this section.

SECTION B: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release. Be specific regarding the types of documents you are authorizing for release. For example, if you are authorizing an individual to obtain PHI related to a recent medical event, specify the date of the medical event, the types of documents you are requesting (e.g. billing records, pre-authorization records, or pharmacy records) and state any types of records you would like to exclude.

SECTION C: PURPOSE OF THIS AUTHORIZATION

Select the reason(s) you've asked for the release of your information. If you have a specific reason, please fill in under **"Other"** and indicate the reason. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information for a pending claims appeal, you would enter ***"To appeal a claim determination"*** or something similar in that block.

SECTION D: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI. For example, if you are authorizing your spouse, adult child, or any other individual to obtain your PHI, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, law firm, insurance agency, etc.) to obtain your PHI, enter the specific name of the organization in these spaces. **Examples include:** ***"Dr. John Smith" or "Mary Doe (spouse)."*** Indicate how the person(s) or organization(s) is related to you (for example, spouse, adult child, etc.) and provide their phone number.

SECTION F: EXPIRATION DATE OF AUTHORIZATION

Check the first box if you want the authorization to end on a certain date. Enter in the date of expiration. Check the second box if you wish for the authorization to expire on a certain event, for example, ***"one year from my signature date."***

SECTION G: SIGNATURE

If you are the member, sign your name and enter the date you signed the form. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.**

If you are the member's personal representative, sign your name, enter the date you signed the form and indicate your representative relationship. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.** You **must** also provide us with a copy of the legal documentation indicating you are the authorized personal representative of the member.

- Examples of legal documents:
  - **Power of Attorney for Health Care —** this document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
  - **Legal Guardianship —** this is when the court appoints someone to care for another person.
  - **Conservatorship of the Person —** this happens when the court appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
  - **Executor of Estate —** this type of document would be used when the person who is being represented has died.

Please keep a copy of the form for your records.

INDIVIDUAL REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI) CONTAINED IN THE DESIGNATED RECORD SET (DRS)

You have the right to inspect your protected health information (PHI) in the Designated Record Set (DRS). You also have the right to request copies of those records. You will receive a response to your request within 30 days after we receive the completed form. If the information is not readily available, CalOptima has up to 60 days to provide you with your PHI. CalOptima may charge a fee of $0.10 per page and any postage fees if you ask for copies of the records to be mailed to you.

To Request a Copy of Your PHI in a DRS:

1. Fill out the entire form and print clearly. **In order to process your request, a photocopy of your valid photo identification (ID) must be included with your request form.**

2. If you would like to appoint another person to have access to or receive your PHI, then you must also complete the CalOptima Authorization for Release of Protected Health Information form. Requests by your personal representative are subject to verification.

3. Please select the type of records you need from the list provided. If you are not sure what you need, please call CalOptima Customer Service toll-free at **1-888-587-8088** for help. .

4. If you were a part of a health network (e.g. Monarch, AltaMed, etc.) during any part of the date range requested, you should also contact that health network. **CalOptima does not have complete copies of your medical records. If you want to look at or get a copy of your medical records, please contact your doctor or clinic.**

5. If you have any questions about your request, please call CalOptima Customer Service toll-free at **1-888-587-8088**, Monday through Friday from 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.

6. Your records may be picked up at CalOptima's office or sent via email or certified postal mail. Requests for records to be faxed must be approved by CalOptima. Records sent via email will be sent secure (encrypted) to the email address provided. However, CalOptima is not responsible for loss of PHI on personal email accounts.

INDIVIDUAL REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI) CONTAINED IN THE DESIGNATED RECORD SET (DRS)

Member Name: _____ Date of Birth: _____ *(mm/dd/yyyy)*

Phone: (____) _____ CalOptima CIN: _____

The types of records listed below are part of the DRS maintained by CalOptima. Please select the types of records you wish to view or receive as well as the date range.

Authorizations
- ☐ Medical Authorization Request(s)
- ☐ Pharmacy Prior Authorization(s) (PA)
- ☐ Notice of Action(s)

Behavioral Health Record(s)
- ☐ Behavioral Health Authorization(s)/Denials
- ☐ Care Management Notes

Case Management
- ☐ Case Management Note(s)
- ☐ Case Management Care Plan(s)
- ☐ Case Management Assessment(s)

Claims/Billing
- ☐ Medical Claims Record(s)
- ☐ Pharmacy Claims Record(s)

Customer Service
- ☐ Member Call Logs

Eligibility
- ☐ Eligibility Record(s)
- ☐ Auto Assignment and Health Network Changes
- ☐ Enrollment Form(s) (Does not apply to Medi-Cal Members)

Grievances and Appeals (GARS)
- ☐ Grievance Case File Record(s)
- ☐ Appeal Case File Record(s)

Health Education and Disease Management
- ☐ Care Plan(s)
- ☐ Assessment(s)
- ☐ Health Ed. and Disease Mgmt. Notes

Long-Term Services and Supports (LTSS)
- ☐ Assessment(s)
- ☐ Authorization(s)
- ☐ Case Management Notes

Multipurpose Senior Services Program (MSSP)
- ☐ Assessment(s)
- ☐ Care Plan(s)
- ☐ Referral Form(s)
- ☐ Progress Notes
- ☐ Application Form

State Hearing(s)
- ☐ State Hearing Record(s)

I am requesting copies of records for the following dates of service: _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Requests submitted without a date range will be considered incomplete.

Delivery method requested (select one):

☐ "Personal" pickup at CalOptima (identification required at the time of pickup)

☐ Mail: _____
Street/Unit *City* *State* *ZIP Code*

☐ Fax (Upon approval): (____) _____ ☐ Email: _____

Identifying information is required (select one):

☐ Copy of ID attached (e.g. valid driver license, birth certificate, benefits ID card, etc.)

☐ If no ID is attached, your signature must be notarized.

Notarized By: _____

Notary Public Number: _____

Date: _____

Unofficial Unless Stamped by Notary Public

Signature Block:

(I understand that to process my request, a copy of valid, government-issued identification (ID), a copy of documentation of legal authority, or a notarized signature must be included with my request form.)

By signing below, I state that I have read this form and know what it means.

_____ _____

Signature of Member/Personal Representative Date

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

CalOptima reserves the right to request legal documentation (e.g., birth certificate, court order, etc.) from the parent/guardian signing on behalf of a dependent member.

Personal Representatives — Please attach legal documentation to verify that you are the conservator, executor of a decedent's will, or have medical decision-making authority for the individual.

Submit the completed and signed request form and copy of ID to CalOptima, either in person, by mail or by fax.

CalOptima
Attn: Office of Compliance (Privacy)
505 City Parkway West, Orange, CA 92868
Fax: 1-714-481-6457

<Date>

<Member Name>
<Address line 1>
<Address Line 2>

RE: Response to Request for Access to Protected Health Information (PHI)

Dear < Member name>:

CalOptima received the request for access to <your/ member's name> Protected Health Information (PHI) contained in CalOptima's Designated Record Set (DRS) on <date received>.

CalOptima licensed healthcare professional has reviewed this request and has denied access to the information. Under federal law, CalOptima are not required to provide the information because [REASON].

If you wish to have the denial review by another licesened health care professional, you may submit a written request for review. This request should be submitted to:

CalOptima Privacy Officer
505 City Parkway West
Orange, CA 92868

If you have any questions about this letter, please contact CalOptima at 1-**714-246-8400** and enter <extension #> and ask for <Employee name>. We are open Monday through Friday from <8 a.m. to 5 p.m.> We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**.

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website at www.caloptima.org, or from CalOptima's Customer Service Department by calling 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday from 8 a.m to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at 1-714-246-8523. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department by calling 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

HIPAA Privacy
Office of Compliance

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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<Date>

<Member Name>
<Address line 1>
<Address Line 2>

RE: Response to Request for Access to Protected Health Information (PHI)

Dear < Member name>:

CalOptima received the request for access to <your/ member's name> Protected Health Information (PHI) contained in CalOptima's Designated Record Set (DRS) on <date received>.

CalOptima licensed healthcare professional has reviewed this request and has denied access to the information. Under federal law, CalOptima are not required to provide the information because [REASON].

This denial is final and is not subject to review according to federal law.

If you have any questions about this letter, please contact CalOptima at 1-**714-246-8400** and enter <extension #> and ask for <Employee name>. We are open Monday through Friday from <8 a.m. to 5 p.m.> We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**.

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website at www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department by calling **1-714-246-8500**.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929
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Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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<Date>

<Member Name>
<Address line 1>
<Address Line 2>

Dear < Member name>:

CalOptima received the request for access to <your/ member's name> Protected Health Information (PHI) contained in CalOptima's Designated Record Set (DRS) on <date received>.

CalOptima is unable to complete your request at this time due to the following reasons:

- ☐ CalOptima *Authorization For Release of Protected Health Information* form is needed. Please complete the enclosed form.
- ☐ CalOptima *Authorization For Release of Protected Health Information* is incomplete. Please complete the missing item highlighted.
- ☐ CalOptima *Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Records Set (DRS)* form is needed. Please complete the enclosed form.
- ☐ CalOptima *Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Records Set (DRS)* form is incomplete. Please complete the missing item highlighted.
- ☐ A copy of a valid, government-issued ID is needed. Please send us a copy.

In order to process your request and avoid further delay, please **complete the missing items listed above and mail or fax it to 1-714-954-2204.**

CalOptima's DRS consists of files created and managed by CalOptima as <your/ the member's> health plan. It does not include treatment or clinical medical records created by <your/ the member's> doctor. CalOptima does not maintain or have access to medical records compiled by hospitals or doctors' offices, such as vaccine records, X-rays, lab results, etc.

If you have any questions about this letter, please contact CalOptima at 1-**714-246-8400** and enter <extension #> and ask for <Employee name>. We are open Monday through Friday from <8 a.m. to 5 p.m.> We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**.

Sincerely,

HIPAA Privacy
Office of Compliance

<Date>

MEMBER PICK-UP AT CALOPTIMA

Member Signature: _____

Date/Time: _____

<Member Name>
<Address line 1>
<Address Line 2>

Dear < Member name>:

CalOptima received on <date received> the attached request for access to <your/member's name> Protected Health Information (PHI) contained in CalOptima's Designated Record Set (DRS).

CalOptima has your DRS for the date range: <month, day, year – month, date, year>.

CalOptima's DRS consists of files created and managed by CalOptima as <your/ the member's> health plan. It does not include treatment or clinical medical records created by <your/ the member's> doctor. CalOptima does not maintain or have access to medical records compiled by hospitals or doctors' offices, such as vaccine records, X-rays, lab results, etc.

Our records show that during the above date range, you were a member of one of the health networks listed below. Health networks — as well as doctors and clinics — maintain their own separate medical records. You may need to contact them directly in order to obtain a complete copy of <your/member's name> medical records.

Health Network	Active Dates with Health Network	Phone
☐ AltaMed Health Network		**1-866-880-7805**
☐ AMVI Care Health Network		**1-866-796-4245**
☐ Arta Western Health Network		**1-800-780-8879**
☐ CHOC Health Alliance		**1-800-424-2462**
☐ Family Choice Health Network		**1-800-611-0111**
☐ Heritage - ADOC Medical Group		**1-800-747-2362**
☐ Heritage - Regal Medical Group		**1-866-654-3471**

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Main: 888-587-8088 | Fax: 714-481-6457 | TDD/TTY: 800-735-2929

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☐ Talbert Medical Group		**1-800-297-6249**
☐ Kaiser Permanente		**1-800-464-4000**
☐ Monarch Family Health Care		**1-888-656-7523**
☐ Noble Mid-Orange County		**1-888-880-8811**
☐ Orange County Advantage Medical Group		**1-714-947-8600**
☐ Prospect Medical Group		**1-800-708-3230**
☐ United Care Medical Group		**1-877-225-6784**

If you have any questions about this letter, please contact CalOptima at **1-714-246-8400**, enter <extension #> and ask for <Employee name>. We are open Monday through Friday from <8 a.m. to 5 p.m.> We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**.

Sincerely,

HIPAA Privacy
Office of Compliance

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929
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Policy ~~#~~:	HH.3006Δ
Title:	**Tracking and Reporting Disclosures of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

FOR 20191205BOD REVIEW

I. PURPOSE

This policy defines the process by which CalOptima shall internally track and report **Disclosures** of a **Member's Protected Health Information (PHI)**

II. POLICY

A. CalOptima shall maintain a tracking process for all oral, written, facsimile, electronic, or other form of **Disclosures** of **PHI** that is not related to **Treatment**, **Payment**, or **Health Care Operations**, to the **Member**, or when the **Member** authorized **Disclosure**, or other functions specified in this policy.

B. CalOptima shall maintain a tracking process for all requests for a **Member's PHI**, other than a request for **Medical Records**, and shall report this information, as applicable, to the **Department of Health Care Services (DHCS)** monthly.

III. PROCEDURE

A. The following categories of **Disclosures** are not required to be included on the report when a **Member** requests an accounting of the **Disclosure** made of his or her **PHI**, as defined in the **Designated Record Set (DRS)**:

1. Used to carry out activities related to **Treatment**, **Payment**, or **Health Care Operations**;

2. Disclosed to the **Member** or **Member's Personal Representative**, or authorized by the **Member**;

3. Incidental **Disclosures**;

4. **Disclosures** made prior to April 14, 2003;

5. For national security, or intelligence purposes; and

6. **Disclosure** of **PHI** directly relevant to an individual's involvement in a **Member's** care, (e.g., family ~~member~~**Member**, other relative, or a close, personal friend of the **Member**, or any other person identified by the **Member**).

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

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B. Any other **Disclosure** shall be recorded and reported to the Privacy Officer or **Designee**. CalOptima shall track routine ~~disclosures~~**Disclosures** which may include, but are not limited to:

1. **Disclosures** required by law;
2. For health oversight activities;
3. Required for public health activities;
4. About victims of abuse, neglect, or domestic violence;
5. To coroners, or medical examiners;
6. To funeral directors;
7. For organ, eye, or tissue donation; and
8. To avert a serious threat to health, or safety.

C. Tracking Routine Recurring **Disclosures**

1. Departments that Disclose **PHI** on a regular basis to the same agency shall maintain a current log with the following elements included in hard copy or in an electronic spreadsheet:
   a. Date of initial **Disclosure**;
   b. Name of person, or organization, receiving the **PHI**;
   c. Address, if known;
   d. Brief description of information Disclosed; and
   e. Brief statement of purpose and the frequency of **Disclosure**.
2. **Disclosure** reports for recurring **Disclosures** shall be summarized to include the above stated information with the number of times the information was Disclosed and the date of the last **Disclosure**.

D. Tracking Non-Recurring **Disclosures**

1. The Office of Compliance shall enter any **Disclosure** made that is not included in the routine recurring **Disclosures** reported and entered into the Office of Compliance **PHI** Tracking Database for tracking and reporting purposes.
2. The following information shall be reported:
   a. **Member** name and identification (ID) number;

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b. Date of the **Disclosure**;

c. Name of organization, or person, who received information, and their address, if known;

d. Brief description of information disclosed;

e. Brief statement of the purpose for the **Disclosure**;

f. Name of the person making the **Disclosure**; and

g. Department of the person making the report.

3. The report for non-recurring routine type of **Disclosures** may be submitted on a Reporting Non-Routine **Disclosures** of **Protected Health Information (PHI)** Form, or emailed with the above information, to the Office of Compliance within three (3) business days of making the routine **Disclosure**.

E. Documentation: The Office of Compliance shall:

1. Enter in the Office of Compliance **PHI** Tracking Database the **Disclosure** reports from other departments and those **Disclosures** reviewed by the Privacy Officer, or **Designee**.

2. Maintain a log of all requests from **Members** for accounting of **Disclosures**~~, including the following information:~~ in accordance with CalOptima Policy HH.3005Δ: **Member** Request for Accounting of **Disclosures**.

~~a. Date request received;~~

~~b. Name of Member or Member's Personal Representative requesting the accounting;~~

~~c. Member identification (ID) number;~~

~~d. Date range requested;~~

~~e. Name of staff person handling the request; and~~

~~f. Date the report was provided to the Member.~~

~~3. Retain the request and a copy of the report given to the Member for no less than six (6) years from the date CalOptima received the request.~~

F. Tracking and Reporting Requests for **PHI** other than a Request for **Medical Records**

1. The Office of Compliance shall track all requests for a **Member's PHI**, other than a request for **Medical Records**, or other requests allowed by law.

2. The Regulatory Affairs and Compliance Department shall report this information, as applicable, to **DHCS** on a monthly basis.

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~~IV. ATTACHMENTS~~
IV. ATTACHMENT(S)

A. Reporting Non-Routine Disclosures of Protected Health Information (PHI) Form

~~V. REFERENCES~~
V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal (Exhibit E, Attachment 2 Program Terms and Conditions, Provision 22)
~~D.~~A. ~~CalOptima PACE Program Agreement~~
~~E. CalOptima Policy AA.1000: Glossary of Terms~~
~~F. CalOptima Policy CMC.1001: Glossary of Terms~~
~~G. CalOptima Policy MA.1001: Glossary of Terms~~
~~H.~~A. ~~CalOptima Privacy Program~~
~~I.~~D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima PACE Program Agreement
F. CalOptima Policy HH.3005Δ: Member Request for Accounting of Disclosures
G. CalOptima Privacy Program
~~J.~~H. Title 45, Code of Federal Regulations, §164.528
~~K.~~I. Volume 65, Federal Register, Number 250

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

None to Date

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

~~A. 12/06/18: Regular Meeting of the CalOptima Board of Directors~~
~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors~~
~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors~~

~~REVIEW/~~

~~VIII.~~I. ~~REVISION HISTORY~~

Date	Meeting
~~Date~~12/01/2016	Regular Meeting of the CalOptima Board of Directors~~Line(s) of Business~~
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

FOR 20191205BOD REVIEW

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Revised	04/01/2007	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Revised	01/01/2008	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Effective	02/02/2008	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	01/01/2010	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	01/01/2010	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	04/01/2013	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	02/01/2014	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	09/01/2014	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	09/01/2014	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	09/01/2015	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3006Δ	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3006Δ	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3006Δ	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised		HH.3006Δ	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
~~Authorized/~~Personal Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The ~~medical records~~Medical Records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, ~~payment~~Payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.

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Term	Definition
Medical Record	A ~~medical record~~Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which compromises the total of each patient's health history. Medical ~~records~~Records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary who is enrolled in a CalOptima Program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing, claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
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 a 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.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the ~~Member's~~Member's health care benefits.

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Policy:	HH.3006Δ
Title:	**Tracking and Reporting Disclosures of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

FOR 20191205BOD REVIEW

I. PURPOSE

This policy defines the process by which CalOptima shall internally track and report **Disclosures** of a **Member's Protected Health Information (PHI)**

II. POLICY

A. CalOptima shall maintain a tracking process for all oral, written, facsimile, electronic, or other form of **Disclosures** of **PHI** that is not related to **Treatment**, **Payment**, or **Health Care Operations**, to the **Member**, or when the **Member** authorized **Disclosure**, or other functions specified in this policy.

B. CalOptima shall maintain a tracking process for all requests for a **Member's PHI**, other than a request for **Medical Records**, and shall report this information, as applicable, to the **Department of Health Care Services (DHCS)** monthly.

III. PROCEDURE

A. The following categories of **Disclosures** are not required to be included on the report when a **Member** requests an accounting of the **Disclosure** made of his or her **PHI**, as defined in the **Designated Record Set (DRS)**:

1. Used to carry out activities related to **Treatment**, **Payment**, or **Health Care Operations**;

2. Disclosed to the **Member** or **Member's Personal Representative**, or authorized by the **Member**;

3. Incidental **Disclosures**;

4. **Disclosures** made prior to April 14, 2003;

5. For national security, or intelligence purposes; and

6. **Disclosure** of **PHI** directly relevant to an individual's involvement in a **Member's** care, (e.g., family **Member**, other relative, or a close, personal friend of the **Member**, or any other person identified by the **Member**).

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

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B. Any other **Disclosure** shall be recorded and reported to the Privacy Officer or **Designee**. CalOptima shall track routine **Disclosures** which may include, but are not limited to:

1. **Disclosures** required by law;

2. For health oversight activities;

3. Required for public health activities;

4. About victims of abuse, neglect, or domestic violence;

5. To coroners, or medical examiners;

6. To funeral directors;

7. For organ, eye, or tissue donation; and

8. To avert a serious threat to health, or safety.

C. Tracking Routine Recurring **Disclosures**

1. Departments that Disclose **PHI** on a regular basis to the same agency shall maintain a current log with the following elements included in hard copy or in an electronic spreadsheet:

   a. Date of initial **Disclosure**;

   b. Name of person, or organization, receiving the **PHI**;

   c. Address, if known;

   d. Brief description of information Disclosed; and

   e. Brief statement of purpose and the frequency of **Disclosure**.

2. **Disclosure** reports for recurring **Disclosures** shall be summarized to include the above stated information with the number of times the information was Disclosed and the date of the last **Disclosure**.

D. Tracking Non-Recurring **Disclosures**

1. The Office of Compliance shall enter any **Disclosure** made that is not included in the routine recurring **Disclosures** reported and entered into the Office of Compliance **PHI** Tracking Database for tracking and reporting purposes.

2. The following information shall be reported:

   a. **Member** name and identification (ID) number;

   b. Date of the **Disclosure**;

   c. Name of organization, or person, who received information, and their address, if known;

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d. Brief description of information disclosed;

e. Brief statement of the purpose for the **Disclosure**;

f. Name of the person making the **Disclosure**; and

g. Department of the person making the report.

3. The report for non-recurring routine type of **Disclosures** may be submitted on a Reporting Non-Routine **Disclosures** of **Protected Health Information (PHI)** Form, or emailed with the above information, to the Office of Compliance within three (3) business days of making the routine **Disclosure**.

E. Documentation: The Office of Compliance shall:

1. Enter in the Office of Compliance **PHI** Tracking Database the **Disclosure** reports from other departments and those **Disclosures** reviewed by the Privacy Officer, or **Designee**.

2. Maintain a log of all requests from **Members** for accounting of **Disclosures** in accordance with CalOptima Policy HH.3005Δ: **Member** Request for Accounting of **Disclosures**.

F. Tracking and Reporting Requests for **PHI** other than a Request for **Medical Records**

1. The Office of Compliance shall track all requests for a **Member's PHI**, other than a request for **Medical Records**, or other requests allowed by law.

2. The Regulatory Affairs and Compliance Department shall report this information, as applicable, to **DHCS** on a monthly basis.

IV. ATTACHMENT(S)

A. Reporting Non-Routine Disclosures of Protected Health Information (PHI) Form

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal (Exhibit E, Attachment 2 Program Terms and Conditions, Provision 22)
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima PACE Program Agreement
F. CalOptima Policy HH.3005Δ: Member Request for Accounting of Disclosures
G. CalOptima Privacy Program
H. Title 45, Code of Federal Regulations, §164.528
I. Volume 65, Federal Register, Number 250

VI. REGULATORY AGENCY APPROVAL(S)

FOR 20191205BOD REVIEW

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Revised	04/01/2007	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Revised	01/01/2008	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Effective	02/02/2008	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	01/01/2010	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	01/01/2010	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	04/01/2013	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	02/01/2014	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	09/01/2014	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	09/01/2014	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	09/01/2015	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3006Δ	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/07/2017	HH.3006Δ	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3006Δ	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.3006Δ	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Personal Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The Medical Records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, Payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Medical Record	A Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which compromises the total of each patient's health history. Medical Records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary who is enrolled in a CalOptima Program.

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Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing, claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
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 a 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.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

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Reporting Non-Routine Disclosures of PHI

Date of Report: _____

Name of person filing report: _____

Date of Disclosure: _____

Name of organization/person that received the PHI: _____

Brief description of content of Disclosure: _____

_____

_____

_____

_____

Purpose of Disclosure: _____

_____

_____

Name of person who Disclosed information: _____

Note: the above information may be submitted via an e-mail as long as all data is included in the body of the e-mail.

FOR USE BY OFFICE OF COMPLIANCE

Date entered in FACETS™: _____

Staff name that entered data: _____

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Policy ~~#:~~:	HH.3015Δ
Title:	**Member Authorization for the Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*Michael Schrader* _____
Effective Date:	04/01/03
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

FOR 2019 1205 BOD REVIEW

I. PURPOSE

This policy describes the circumstances and process for obtaining a **Member's** (or from their **Personal Representative**) **Authorization** for the **Use** and **Disclosure** of a **Member's Protected Health Information (PHI)**.

II. POLICY

A. CalOptima shall only **Use** or Disclose a **Member's PHI** pursuant to a written **Authorization** from the **Member**, or the **Member's Personal Representative**, unless otherwise permitted, or required, by the **Health Insurance Portability and Accountability Act (HIPAA)** and other applicable federal and state laws.

B. CalOptima will not condition **Treatment**, **Payment**, enrollment, or benefits eligibility on an individual granting an **Authorization**.

C. CalOptima shall obtain, review, and confirm that it has a valid **Authorization** from the **Member**, or the **Member's Personal Representative**, in accordance with **HIPAA**, other applicable federal and state laws, and this policy prior to a **Use** or **Disclosure** of **PHI** that requires an ~~authorization~~**Authorization**.

D. CalOptima may **Use** and Disclose a **Member's PHI** without a **Member's Authorization** for **Treatment**, **Payment** and Healthcare Operations as permitted by **HIPAA** and other applicable federal and state laws and CalOptima Policy HH.3011Δ: **Uses** and **Disclosures** of **Protected Health Information (PHI)** for **Treatment**, **Payment**, and **Health Care Operations**~~.~~.

E. **Uses** and **Disclosures** involving **Member PHI** that has been properly "**De-Identified**," pursuant to the requirements in Title 45, Code of Federal Regulations, Section 164.514, do not require a **Member's Authorization**.

III. PROCEDURE

A. All valid ~~authorizations~~**Authorizations** shall contain specified core elements and requirements, in accordance with Title 45, Code of Federal Regulations, Section 164.508(c) and California Civil

* Terms in **bold** are included in the Glossary.
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Code, Section 56.11. CalOptima's **Authorization** Form for Release of **PHI** contains the required elements in compliance with Title 45, Code of Federal Regulations, Section 164.508(c) and California Civil Code, Section 56.11:

1. Is handwritten by the person who signs it or is in a typeface no smaller than fourteen (14)-point type.

2. A description of the information to be **Used** or Disclosed;

3. The name of the person or organization that will **Use** or Disclose the **PHI**;

4. The name of the person or organization that will receive the **PHI**;

5. Identifies the ~~uses~~**Uses** and limitations on ~~uses~~**Uses** for which the **PHI** will be disclosed (except for requests by **Member**, which can indicate "at **Member's** request" without further explanation);

6. The specific expiration date;

7. **Member's** or **Member's Personal Representative's** signature and the date. If the ~~authorization~~**Authorization** is signed by a **Personal Representative** of the individual, a description of such ~~representative's~~**Representative's** authority to act for the individual must also be provided. (*e.g.* parent, power of attorney for health care, court-appointed guardian, etc.); and

8. In addition to the requirements above, the following statements must also be included in the ~~authorization~~**Authorization**;

   a. A statement that the **Member** has the right to revoke the ~~authorization~~**Authorization**, in writing, and any exceptions to this right;

   b. A statement that CalOptima will not condition **Treatment**, or **Payment**, on the **Member** signing the **Authorization** request;

   c. A statement informing the ~~member~~**Member** about the potential for information to be redisclosed and no longer protected by the state or federal privacy rule;

   d. A statement that the **Member** can refuse to sign the **Authorization**;

   e. A statement that the **Member** is entitled to a copy of the signed **Authorization**. A copy of the signed **Authorization** must be given to the **Member**; or

   f. A statement when any **Disclosure** will result in either direct, or indirect, **Payment** to CalOptima from the receiver of the **PHI**.

B. The **Authorization** must be completed and must be signed by the person with authority to authorize **Use** or **Disclosure** of **PHI** (i.e., the **Member** or their **Personal Representative**).

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C. All **Uses** and **Disclosures** made pursuant to an **Authorization** must be consistent with the **Authorization**.

D. An **Authorization** shall be considered invalid if the document submitted contains any of the following defects:

1. The expiration date has passed~~, or the expiration date is known by CalOptima to have passed;~~;
2. The **Authorization** does not contain all the required elements;
3. The **Authorization** is known by CalOptima to have been revoked;
4. The **Authorization** is combined with any other document in a manner that is not permitted under the privacy standard;
5. The signature serves some purpose in addition to the ~~authorization~~**Authorization** to disclose **PHI**; or
6. The **Authorization** contains material information known by CalOptima to be false.

E. CalOptima staff shall verify the identity of the **Personal Representative**, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for **Disclosures** of Protected Health Information.

F. Revocation of **Authorization**

1. A **Member** may revoke an **Authorization** at any time by ~~writing~~submitting the Revocation of **Authorization** for Release of Protected Health Information form to CalOptima and requesting that the **Authorization** be revoked.
2. The revocation will not apply to those **Uses** or **Disclosures** made ~~with~~in reliance on the **Authorization** prior to the receiving the request to revoke the **Authorization**.

G. All signed **Authorization** and revocation notices are retained on file for ten (10) years from the date the documents are received by CalOptima.

H. CalOptima shall mail a **HIPAA Authorization** for Release of Information Form to **Members** requesting ~~disclosure~~**Disclosure** of **PHI** when such form is required by **HIPAA** privacy regulations.

1. Upon receipt of signed and completed form via fax, or mail, the CalOptima Privacy Officer, or Designee, shall review, approve, or deny, and disclose requested information when appropriate, per the signed form.

I. CalOptima shall obtain **Authorization** from the **Member** for any **Use** or **Disclosure** of psychotherapy notes except in the following situations:

1. **Use** by the originator of the psychotherapy notes for **Treatment**;

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2. **Use** or **Disclosure** by a covered entity's own training program for students, trainees, or practitioners in mental health, under supervision, to improve skills;

3. **Use** by a **Provider** for purposes of diagnosis, or **Treatment**, of the **Member**;

4. **Use** or **Disclosure** by a covered entity to defend itself in a legal action, or other proceeding, brought by the **Member**; or

5. Evaluation, or oversight, of the practitioner creating the psychotherapy notes.

J. **Authorization** shall be obtained from the **Member** for any **Use** or **Disclosure** of **PHI** for **Marketing**, except when:

1. Face-to-face communication is made by CalOptima to the **Member**; or

2. The communication is in the form of a promotional gift of nominal value provided by CalOptima.

~~IV. ATTACHMENTS~~

~~A. Authorization for Release of Protected Health Information (PHI)~~

IV. ~~Individual~~ ATTACHMENT(S)

A. Instruction Sheet for CalOptima Health Insurance Portability and Accountability Act (HIPAA) Authorization for Release of Protected Health Information ~~Form~~(PHI)
B. Authorization for Release of Protected Health Information (PHI)
~~B.~~C. HIPAA Authorization Checklist

~~V. REFERENCES~~

~~C.~~D. Revocation of Authorization for Release of Protected Health Information (PHI) – Medi-Cal
~~D.~~E. Revocation of Authorization for Release of Protected Health Information (PHI) – OneCare/OneCare Connect
~~E.~~F. Revocation of Authorization for Release of Protected Health Information (PHI) – PACE
G.

V. REFERENCE(S)

A. California Civil Code, §§56.10(c), 56.11(b) and 56.104
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~E.~~F. CalOptima PACE Program Agreement

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~~F.~~G. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information
~~G.~~H. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
~~H.~~I. CalOptima Policy HH.3011Δ: Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
~~I.~~A. ~~CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
J. NCQA Standard MED5 Privacy and Confidentiality: Factor B – 2017
K. Title 22, Code of California Regulations (C.C.R.), §51009
L. Title 45, Code of Federal Regulations (C.F.R.), §§164.502(a)(iv), 164.506(a), and 164.508, 164.512
M. Welfare & Institutions Code, §14100.2

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

None to Date

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

~~A. 12/06/18: Regular Meeting of the CalOptima Board of Directors~~
~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors~~
~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors~~

~~REVIEW/~~

~~VIII.~~I. ~~REVISION HISTORY~~

Date	Meeting
~~Date~~12/06/2018	Regular Meeting of the CalOptima Board of Directors~~Line(s) of Business~~
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Effective	06/01/2005	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	04/01/2007	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2008	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2008	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	09/01/2009	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	09/01/2009	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	01/01/2010	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2011	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2013	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	05/01/2013	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	05/01/2013	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	08/01/2013	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	01/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	06/01/2014	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	09/01/2014	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	11/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	11/01/2014	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	09/01/2015	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
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Revised	09/01/2015	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3015Δ	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Retired	12/01/2016	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare OneCare Connect PACE
Reviewed	05/01/2017	HH.3015Δ	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3015Δ	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3015Δ	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent ~~authorization~~Authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code Section 14100.2.
De-~~identified~~Identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be ~~used~~Used to identify a Member.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	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.
Marketing	Has the meaning given such term in 45, Code of Federal Regulations, Section 164.501. 1. Except as provided in paragraph (2) of this definition, ~~marketing~~Marketing means to make a communication about a product or service that encourages recipients of the communication to purchase or ~~use~~Use the product or service. 2. Marketing does not include a communication made: i. To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the covered entity in exchange for making the communication is reasonably related to the covered entity's cost of making the communication. ii. For the following ~~treatment~~Treatment and ~~health care operations~~Health Care Operations purposes, except where the covered entity receives financial remuneration in exchange for making the communication: a. For ~~treatment~~Treatment of an individual by a health care ~~provider~~Provider, including case management or care coordination for the individual, or to direct or recommend

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Term	Definition
	alternative ~~treatments~~Treatments, therapies, health care ~~providers~~Providers, or settings of care to the individual; b. To describe a health-related product or service (or ~~payment~~Payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communications about: the entities participating in a health care ~~provider~~Provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or c. For case management or care coordination, contacting of individuals with information about ~~treatment~~Treatment alternatives, and related functions to the extent these activities do not fall within the definition of ~~treatment~~Treatment.
Member	A beneficiary who is enrolled in a CalOptima Program.
~~Minimum Necessary~~	~~The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.~~
Payment	Activities carried out by CalOptima including: 1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and 3. Utilization review activities including pre-certification, pre-~~authorization~~Authorization, concurrent, or retrospective review of services.
Personal Representative	Has the meaning 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 and as further described in CalOptima Policy HH.3009Δ: Access, Use, and Disclosure of PHI to a Member's Personal Representative.

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Term	Definition
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~~Used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary ~~provider~~Provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care ~~providers~~Providers; and coordination with third parties for services related to the management of the ~~Member's~~Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3015Δ
Title:	**Member Authorization for the Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*Michael Schrader* _____
Effective Date:	04/01/03
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

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I. PURPOSE

This policy describes the circumstances and process for obtaining a **Member's** (or from their **Personal Representative**) **Authorization** for the **Use** and **Disclosure** of a **Member's Protected Health Information (PHI)**.

II. POLICY

A. CalOptima shall only **Use** or Disclose a **Member's PHI** pursuant to a written **Authorization** from the **Member**, or the **Member's Personal Representative**, unless otherwise permitted, or required, by the **Health Insurance Portability and Accountability Act (HIPAA)** and other applicable federal and state laws.

B. CalOptima will not condition **Treatment**, **Payment**, enrollment, or benefits eligibility on an individual granting an **Authorization**.

C. CalOptima shall obtain, review, and confirm that it has a valid **Authorization** from the **Member**, or the **Member's Personal Representative**, in accordance with **HIPAA**, other applicable federal and state laws, and this policy prior to a **Use** or **Disclosure** of **PHI** that requires an **Authorization**.

D. CalOptima may **Use** and Disclose a **Member's PHI** without a **Member's Authorization** for **Treatment**, **Payment** and Healthcare Operations as permitted by **HIPAA** and other applicable federal and state laws and CalOptima Policy HH.3011Δ: **Uses** and **Disclosures** of **Protected Health Information (PHI)** for **Treatment**, **Payment**, and **Health Care Operations**.

E. **Uses** and **Disclosures** involving **Member PHI** that has been properly "**De-Identified**," pursuant to the requirements in Title 45, Code of Federal Regulations, Section 164.514, do not require a **Member's Authorization**.

III. PROCEDURE

A. All valid **Authorizations** shall contain specified core elements and requirements, in accordance with Title 45, Code of Federal Regulations, Section 164.508(c) and California Civil Code, Section

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

Back to Agenda

56.11. CalOptima's **Authorization** Form for Release of **PHI** contains the required elements in compliance with Title 45, Code of Federal Regulations, Section 164.508(c) and California Civil Code, Section 56.11:

1. Is handwritten by the person who signs it or is in a typeface no smaller than fourteen (14)-point type.

2. A description of the information to be **Used** or Disclosed;

3. The name of the person or organization that will **Use** or Disclose the **PHI**;

4. The name of the person or organization that will receive the **PHI**;

5. Identifies the **Uses** and limitations on **Uses** for which the **PHI** will be disclosed (except for requests by **Member**, which can indicate "at **Member's** request" without further explanation);

6. The specific expiration date;

7. **Member's** or **Member's Personal Representative's** signature and the date. If the **Authorization** is signed by a **Personal Representative** of the individual, a description of such **Representative's** authority to act for the individual must also be provided. (*e.g.* parent, power of attorney for health care, court-appointed guardian, etc.); and

8. In addition to the requirements above, the following statements must also be included in the **Authorization**;

   a. A statement that the **Member** has the right to revoke the **Authorization**, in writing, and any exceptions to this right;

   b. A statement that CalOptima will not condition **Treatment**, or **Payment**, on the **Member** signing the **Authorization** request;

   c. A statement informing the **Member** about the potential for information to be redisclosed and no longer protected by the state or federal privacy rule;

   d. A statement that the **Member** can refuse to sign the **Authorization**;

   e. A statement that the **Member** is entitled to a copy of the signed **Authorization**. A copy of the signed **Authorization** must be given to the **Member**; or

   f. A statement when any **Disclosure** will result in either direct, or indirect, **Payment** to CalOptima from the receiver of the **PHI**.

B. The **Authorization** must be completed and must be signed by the person with authority to authorize **Use** or **Disclosure** of **PHI** (i.e., the **Member** or their **Personal Representative**).

C. All **Uses** and **Disclosures** made pursuant to an **Authorization** must be consistent with the **Authorization**.

D. An **Authorization** shall be considered invalid if the document submitted contains any of the following defects:

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1. The expiration date has passed;

2. The **Authorization** does not contain all the required elements;

3. The **Authorization** is known by CalOptima to have been revoked;

4. The **Authorization** is combined with any other document in a manner that is not permitted under the privacy standard;

5. The signature serves some purpose in addition to the **Authorization** to disclose **PHI**; or

6. The **Authorization** contains material information known by CalOptima to be false.

E. CalOptima staff shall verify the identity of the **Personal Representative**, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for **Disclosures** of Protected Health Information.

F. Revocation of **Authorization**

1. A **Member** may revoke an **Authorization** at any time by submitting the Revocation of **Authorization** for Release of Protected Health Information form to CalOptima and requesting that the **Authorization** be revoked.

2. The revocation will not apply to those **Uses** or **Disclosures** made in reliance on the **Authorization** prior to the receiving the request to revoke the **Authorization**.

G. All signed **Authorization** and revocation notices are retained on file for ten (10) years from the date the documents are received by CalOptima.

H. CalOptima shall mail a **HIPAA Authorization** for Release of Information Form to **Members** requesting **Disclosure** of **PHI** when such form is required by **HIPAA** privacy regulations.

1. Upon receipt of signed and completed form via fax, or mail, the CalOptima Privacy Officer, or Designee, shall review, approve, or deny, and disclose requested information when appropriate, per the signed form.

I. CalOptima shall obtain **Authorization** from the **Member** for any **Use** or **Disclosure** of psychotherapy notes except in the following situations:

1. **Use** by the originator of the psychotherapy notes for **Treatment**;

2. **Use** or **Disclosure** by a covered entity's own training program for students, trainees, or practitioners in mental health, under supervision, to improve skills;

3. **Use** by a **Provider** for purposes of diagnosis, or **Treatment**, of the **Member**;

4. **Use** or **Disclosure** by a covered entity to defend itself in a legal action, or other proceeding, brought by the **Member**; or

5. Evaluation, or oversight, of the practitioner creating the psychotherapy notes.

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J. **Authorization** shall be obtained from the **Member** for any **Use** or **Disclosure** of **PHI** for **Marketing**, except when:

1. Face-to-face communication is made by CalOptima to the **Member**; or

2. The communication is in the form of a promotional gift of nominal value provided by CalOptima.

IV. ATTACHMENT(S)

A. Instruction Sheet for CalOptima Health Insurance Portability and Accountability Act (HIPAA) Authorization for Release of Protected Health Information (PHI)
B. Authorization for Release of Protected Health Information (PHI)
C. HIPAA Authorization Checklist
D. Revocation of Authorization for Release of Protected Health Information (PHI) – Medi-Cal
E. Revocation of Authorization for Release of Protected Health Information (PHI) – OneCare/OneCare Connect
F. Revocation of Authorization for Release of Protected Health Information (PHI) – PACE
G.

V. REFERENCE(S)

A. California Civil Code, §§56.10(c), 56.11(b) and 56.104
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
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G. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information
H. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
I. CalOptima Policy HH.3011Δ: Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
J. NCQA Standard MED5 Privacy and Confidentiality: Factor B – 2017
K. Title 22, Code of California Regulations (C.C.R.), §51009
L. Title 45, Code of Federal Regulations (C.F.R.), §§164.502(a)(iv), 164.506(a), and 164.508, 164.512
M. Welfare & Institutions Code, §14100.2

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

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1

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
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Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent Authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code Section 14100.2.
De-Identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be Used to identify a Member.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	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.
Marketing	Has the meaning given such term in 45, Code of Federal Regulations, Section 164.501. 1. Except as provided in paragraph (2) of this definition, Marketing means to make a communication about a product or service that encourages recipients of the communication to purchase or Use the product or service. 2. Marketing does not include a communication made: i. To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the covered entity in exchange for making the communication is reasonably related to the covered entity's cost of making the communication. ii. For the following Treatment and Health Care Operations purposes, except where the covered entity receives financial remuneration in exchange for making the communication: a. For Treatment of an individual by a health care Provider, including case management or care coordination for the individual, or to direct or recommend alternative Treatments, therapies, health care Providers, or settings of care to the individual; b. To describe a health-related product or service (or Payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communications about: the entities

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Term	Definition
	participating in a health care Provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or c. For case management or care coordination, contacting of individuals with information about Treatment alternatives, and related functions to the extent these activities do not fall within the definition of Treatment.
Member	A beneficiary who is enrolled in a CalOptima Program.
Payment	Activities carried out by CalOptima including: 1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and 3. Utilization review activities including pre-certification, pre-Authorization, concurrent, or retrospective review of services.
Personal Representative	Has the meaning 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 and as further described in CalOptima Policy HH.3009Δ: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
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.
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.

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Term	Definition
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Fill out **ALL** sections of this form to allow CalOptima to release your protected health information (PHI) to another person or agency. This form is **ONLY** to release the information. It will not allow anyone to make health care decisions for you.

SECTION A: Member Information

Last Name: _____ First Name: _____

CIN: _____ Date of Birth: _____ *mm/dd/yyyy*

Address: _____

Street/Unit Number *City* *State* *Zip Code*

Best phone number to contact you: _____

Instructions: Mark X inside the box next to your selected option.

SECTION B: Information That Can Be Released

I allow CalOptima to release:

☐ Any and all of my PHI

☐ Only release the following: (list what you allow):

_____

_____

I allow the release of PHI about:
(Initial if any of the below boxes are checked)

☐ Mental health treatment Initial:_____
☐ Alcohol / drug treatment Initial:_____

NOTE: These details will not be released unless you approve first.

SECTION C: Purpose of Authorization

I am releasing this information for:

☐ Personal Use ☐ Legal

☐ Insurance ☐ Other (please specify.): _____

SECTION D: Person(s) or Agency Allowed to Get PHI

I allow CalOptima to release my PHI to the person or agency below. I know this authorization starts when I sign and return this form. The person getting the information must be 18 years of age or older.

Person /Agency's Name(s): _____

Relationship to Member: _____ Phone: _____

SECTION E: My Rights

- I may stop this authorization at any time by sending a **written** notice to: CalOptima, Attn: Enrollment & Reconciliation, 505 City Parkway West, Orange, CA 92868.
- Notice to stop this authorization will not change how CalOptima used or released my PHI before getting my letter.
- The person or agency who gets my PHI from CalOptima may show it to others. In this case, my PHI may no longer be protected by HIPAA Privacy Rules.
- I do not have to fill out this form. Not filling out this form will not change my health care benefits or payment for my health care services.
- I have the right to look at or get a copy of my PHI that is being used or released by this authorization.
- I have the right to get a copy of this form.

SECTION F: End Date of Approval

This authorization for release of information to the named persons or agency will end on: _____ (specific date or event).

**** If an end date or event is not provided, the authorization will not be valid. ****

SECTION G: Signature

I understand that to process my request, a copy of valid government-issued identification (ID), a copy of documentation of legal authority, or a notarized signature must be attached with my request form.

By signing below, I have read this form and know what it means.

_____ _____

Signature of Member/Personal Representative Date

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

CalOptima reserves the right to request legal documentation (e.g., birth certificate, court order, etc.) from the parent/guardian signing on behalf of a dependent member.

Personal Representatives Only: What rights do you have to request health information?

Print Name: _____

- ☐ Conservator
- ☐ Executor of Will
- ☐ Administrator of Estate
- ☐ Medical Power of Attorney
- ☐ Other_____

NOTE: You must attach legal documentation to verify that you are the conservator, executor of a decedent's will, or have medical decision-making authority for the individual.

Please mail this form to CalOptima, Attn: Enrollment & Reconciliation, 505 City Parkway West, Orange CA 92868, or fax it to **1-714-338-3104**.

STOP

For CalOptima Use Only:

Staff Name: _____ How was identity verified? In person/Phone

Signature: Date verified:

INSTRUCTION SHEET FOR CALOPTIMA HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or organization. Please complete all items of information in this section.

SECTION B: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release. Be specific regarding the types of documents you are authorizing for release. For example, if you are authorizing an individual to obtain PHI related to a recent medical event, specify the date of the medical event, the types of documents you are requesting (e.g. billing records, pre-authorization records, or pharmacy records) and state any types of records you would like to exclude.

SECTION C: PURPOSE OF THIS AUTHORIZATION

Select the reason(s) you've asked for the release of your information. If you have a specific reason, please fill in under **"Other"** and indicate the reason. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information for a pending claims appeal, you would enter ***"To appeal a claim determination"*** or something similar in that block.

SECTION D: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI. For example, if you are authorizing your spouse, adult child, or any other individual to obtain your PHI, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, law firm, insurance agency, etc.) to obtain your PHI, enter the specific name of the organization in these spaces. **Examples include:** ***"Dr. John Smith" or "Mary Doe (spouse)."*** Indicate how the person(s) or organization(s) is related to you (for example, spouse, adult child, etc.) and provide their phone number.

SECTION F: EXPIRATION DATE OF AUTHORIZATION

Check the first box if you want the authorization to end on a certain date. Enter in the date of expiration. Check the second box if you wish for the authorization to expire on a certain event, for example, ***"one year from my signature date."***

SECTION G: SIGNATURE

If you are the member, sign your name and enter the date you signed the form. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.**

If you are the member's personal representative, sign your name, enter the date you signed the form and indicate your representative relationship. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.** You **must** also provide us with a copy of the legal documentation indicating you are the authorized personal representative of the member.

- Examples of legal documents:
  - **Power of Attorney for Health Care —** this document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
  - **Legal Guardianship —** this is when the court appoints someone to care for another person.
  - **Conservatorship of the Person —** this happens when the court appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
  - **Executor of Estate —** this type of document would be used when the person who is being represented has died.

Please keep a copy of the form for your records.

HIPAA Authorization Checklist

The following checklist is utilized to assess the validity of the authorization submitted with requests for release of information on a **non-CalOptima** HIPAA Authorization for Release of Information. The authorization must contain the following core elements and required statements.

#	**Requirements for Authorization to Disclose Patient Health Information or Records (45 CFR, 164.508(c) and California Civil Code, Section 56.11)**	☐
1	Authorization provides a description of the member's protected health information to be used or disclosed that identifies the information in a specific and meaningful fashion.	
2	Authorization identifies CalOptima as authorized to make the disclosure.	
3	Authorization identifies the person's name or organization authorized to whom CalOptima may make the disclosure.	
4	Authorization identifies the uses and limitations of uses for the disclosure. The statement "at the request of the member" is a sufficient description for the use and disclosure when a member initiates the authorization and does not, or elects not to, provide a statement of the purpose.	
5	Authorization identifies a specific expiration date.	
6	Authorization contains the signature of the member or member's authorized legal representative.	
7	If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided. (*e.g.* parent, power of attorney for health care, court-appointed guardian, etc.)	
8	Authorization includes the date on which the authorization is signed.	
9	Authorization contains a statement informing the member regarding the right to revoke the authorization in writing and a description how to do so.	
10	Authorization contains a statement informing the member about the organization's ability or inability to condition treatment, payment, enrollment or eligibility for benefits.	
11	Authorization contains a statement informing the member about the potential for information to be re-disclosed and no longer protected by the state or federal privacy rule.	
12	Authorization contains a statement informing the member that he or she has the right to receive a copy of the signed authorization.	
13	Authorization is written in plain language	
14	Is handwritten by the person who signs it or is in a typeface no smaller than 14-point type.	
15	The signature serves no purpose other than authorizing the disclosure of PHI	

Revocation of Authorization for Release of Protected Health Information

* *This form revokes, withdraws and stops the authorization I gave to disclose my Protected Health Information (PHI) to a previously authorized recipient.*

Section A: Member Stopping Authorization to Release Protected Health Information (PHI)

Member name: _____ Date of birth: _____

Member CIN: _____ Phone: _____

Section B: Revocation of Authorization

I hereby revoke, withdraw and stop the Authorization for Release of Protected Health Information that I previously gave to CalOptima to disclose my Protected Health Information (PHI) to the following person or organization:

Name of person or organization previously authorized to receive PHI: _____

Relationship to member: _____

Address: _____ Phone: _____

Authorization Signed Date (if known): _____/_____/_____

____Revoke, withdraw, and stop ALL of the PHI authorized to be released.

____Revoke, withdraw and stop only the following categories of information authorized to be released:

_____

_____

I understand that by signing below, I am stopping my authorization to disclose my Protected Health Information (PHI). I understand my PHI may have already been shared because of the authorization I gave in the past. I understand that this Revocation of Authorization for Release of Protected Health Information (PHI) shall not go into effect until it is received and processed by CalOptima. I further understand that the revocation will only apply to future disclosures or actions regarding my PHI. I cannot cancel actions or disclosures made while the authorization was in effect and valid. I also understand that this revocation only applies to the authorization I gave to share my PHI with the person or organization named in Section B. It does not cancel any other Authorization for Release of Protected Health Information (PHI) forms I signed. This request does not apply to any uses or disclosures permitted or required by law.

_____

Signature of member or personal representative Date

_____

Print name of member or personal representative Relationship (parent, legal guardian, personal representative)

Revocation of Authorization for Release of Protected Health Information

* *This form revokes, withdraws and stops the authorization I gave to disclose my Protected Health Information (PHI) to a previously authorized recipient.*

Section A: Member Stopping Authorization to Release Protected Health Information (PHI)

Member name: _____ Date of birth: _____

Member CIN: _____ Phone: _____

Section B: Revocation of Authorization

I hereby revoke, withdraw and stop the Authorization for Release of Protected Health Information that I previously gave to CalOptima to disclose my Protected Health Information (PHI) to the following person or organization:

Name of person or organization previously authorized to receive PHI: _____

Relationship to member: _____

Address: _____ Phone: _____

Authorization Signed Date (if known): _____/_____/_____

____Revoke, withdraw, and stop ALL of the PHI authorized to be released.

____Revoke, withdraw and stop only the following categories of information authorized to be released:

_____

_____

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_____

Signature of member or personal representative Date

_____

Print name of member or personal representative Relationship (parent, legal guardian, personal representative)

Revocation of Authorization for Release of Protected Health Information

* *This form revokes, withdraws and stops the authorization I gave to disclose my Protected Health Information (PHI) to a previously authorized recipient.*

Section A: Member Stopping Authorization to Release Protected Health Information (PHI)

Member name: _____ Date of birth: _____

Member CIN: _____ Phone: _____

Section B: Revocation of Authorization

I hereby revoke, withdraw and stop the Authorization for Release of Protected Health Information that I previously gave to CalOptima to disclose my Protected Health Information (PHI) to the following person or organization:

Name of person or organization previously authorized to receive PHI: _____

Relationship to member: _____

Address: _____ Phone: _____

Authorization Signed Date (if known): _____/_____/_____

____Revoke, withdraw, and stop ALL of the PHI authorized to be released.

____Revoke, withdraw and stop only the following categories of information authorized to be released:

_____

_____

I understand that by signing below, I am stopping my authorization to disclose my Protected Health Information (PHI). I understand my PHI may have already been shared because of the authorization I gave in the past. I understand that this Revocation of Authorization for Release of Protected Health Information (PHI) shall not go into effect until it is received and processed by CalOptima. I further understand that the revocation will only apply to future disclosures or actions regarding my PHI. I cannot cancel actions or disclosures made while the authorization was in effect and valid. I also understand that this revocation only applies to the authorization I gave to share my PHI with the person or organization named in Section B. It does not cancel any other Authorization for Release of Protected Health Information (PHI) forms I signed. This request does not apply to any uses or disclosures permitted or required by law.

_____

Signature of member or personal representative Date

_____

Print name of member or personal representative Relationship (parent, legal guardian, personal representative)

Policy~~#~~:	_____HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader_____
Effective Date:	11/01/1998
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

FOR BOD REVIEW

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an **Immediate Corrective Action Plan (ICAP)*** or **Corrective Action Plan (CAP)** for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct **Auditing**, operational **Monitoring**, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an **ICAP** or **CAP** response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved **ICAP** or **CAP** response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's **ICAP** or **CAP** request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's **ICAP**, or **CAP**, request may lead to further action. CalOptima may impose **Sanctions** for the underlying non-compliant performance that gave rise to the **ICAP** or **CAP** request, or the failure to develop, submit, and meet the requirements of the **ICAP** or **CAP** request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

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

III. PROCEDURE

A. Basis for an **ICAP** or **CAP**

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, **Audit**s, and conduct ongoing **Monitoring** and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

   a. CalOptima's Office of Compliance may issue an **ICAP**/**CAP** request as a result of **Audit**s conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

   b. CalOptima's Office of Compliance may issue an **ICAP**/**CAP** request as a result of an **ICAP**/**CAP** request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an **ICAP**, or **CAP** request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an **ICAP** or **CAP** potentially warrants **Employee** disciplinary action.

B. **ICAP** and **CAP** Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized **ICAP** and **CAP** request template.

2. Non-compliance with specific requirements that have the potential to cause significant **Member** harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an **ICAP** response.

   a. If the finding requires an **ICAP** request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the **ICAP** request.

   b. The internal department or FDR shall provide a written response within three (3) business days of receiving an **ICAP** request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the **ICAP** response, the internal department or FDR is required to resolve the issue in a manner and timeframe deemed appropriate by CalOptima's Office of Compliance.

3. A **CAP** request is the result of material non-compliance with specific requirements that does not rise to the level of an **ICAP** request.

   a. The internal department or FDR is required to respond to the **CAP** request within fourteen (14) calendar days. CalOptima's Compliance Officer or **Designee** may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the **CAP** response, the internal department or FDR is required to resolve the issue in a manner and timeframe deemed appropriate by CalOptima's Office of Compliance.

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4. An **ICAP** or **CAP** response shall include the following elements:

    a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

    b. Steps taken to resolve the deficiency;

    c. Steps taken to avoid reoccurrence;

    d. Method for implementation and completion of **ICAP** response or **CAP** response;

    e. Individual(s) responsible for implementation of the **ICAP** response or **CAP** response;

    f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

    g. **ICAP** response or **CAP** response completion date(s), as applicable.

C. Unacceptable Resolution to an **ICAP** or **CAP**

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

    a. A summary of previous outreach and required action(s);

    b. An explanation of why that the resolution was not acceptable, or why a response was not received;

    c. A revised response timeline of two (2) business days for an **ICAP**;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or **Designee**.

    d. A revised response timeline of five (5) business days for a **CAP**;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or **Designee**.

    e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

    f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their **Designee**; and

    g. Possibility of referral to the **Audit & Oversight Committee** and the Compliance Committee.

~~In the event the **CAP** is not successfully completed within ninety (90) calendar days of issuance, CalOptima's Office of Compliance shall report the **CAP** status to the AOC.~~

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~~The AOC shall review the outstanding **CAP** items to determine, at its discretion, whether the **CAP** deadline should be extended.~~

D. Acceptable Resolution with **ICAP** or **CAP** Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an **ICAP** or **CAP** response requires **Monitoring** or a focused **Audit**, the **ICAP** or **CAP** response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

    a. A response may be accepted and closed simultaneously if **Monitoring** or a focused **Audit** is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or **Designee**, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

    a. An acknowledgement of acceptance;

    b. A description of follow up actions which shall include, but is not limited to:

        i. Submission of finalized documentation; and/or

        ii. Focused **Audit**, as described in Section III.E. of this Policy; and/or

        iii. **Monitoring**, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or **Designee**, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

    a. An acknowledgement of closure;

    b. The effective date of closure; and

    c. Consequences of repeat deficiencies.

E. Focused **Audit**s

1. CalOptima's Office of Compliance may conduct a focused **Audit** of an internal department or FDR to confirm implementation of the accepted **ICAP** or **CAP** response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, **Audit** period, and **Audit** deliverables that shall be required to complete the focused **Audit**.

3. CalOptima's Office of Compliance may continue to Monitor and/or **Audit** an internal department or FDR for performance of issues and/or functions related to the **ICAP** or **CAP** request.

F. **Monitoring** Period

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1. CalOptima's Office of Compliance may conduct **Monitoring** of the internal department's or FDR's resolution to confirm implementation of the accepted **ICAP** or **CAP** response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined timeframe, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, **Monitoring** period, and deliverables that shall be required to complete the **Monitoring**.

4. CalOptima's Office of Compliance may continue to **Monitor** and/or **Audit** an internal department's or FDR's performance of issues and/or functions related to the **ICAP** or **CAP** request.

G. Failure to Maintain Adequate Resolution

1. If during the **Monitoring** period or the focused **Audit** the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance ~~shall~~may issue the internal department or FDR an **ICAP** or **CAP** request, as appropriate.

2. If an **ICAP** request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or **Designee**.

3. The **ICAP** request shall require the information as described in Section III.B.4. of this Policy.

H. **ICAP** and **CAP** Tracking and Reporting

1. CalOptima's Office of Compliance shall track all **CAP** and **ICAP** requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all **CAP**/**ICAP** requests to the **Audit & Oversight Committee** and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance issues an **ICAP** request with respect to the CalOptima Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager for Medi-Cal within three (3) business days of issuance.

4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the **Audit & Oversight Committee** and the Compliance Committee by the Office of Compliance for further action.

~~IV. ATTACHMENTS~~
IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCES

A. CalOptima Compliance Plan

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B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

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

None to Date

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

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 08/02/18: Regular Meeting of the CalOptima Board of Directors
C. 12/07/17: Regular Meeting of the CalOptima Board of Directors
D. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

FOR 20191205BOD REVIEW

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities 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.
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.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a ~~Member~~Member under a CalOptima Program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	An enrollee-beneficiary of a CalOptima program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

FOR 2019 12/05 BOD REVIEW

Policy:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader_____
Effective Date:	11/01/1998
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

FOR BOD REVIEW

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an **Immediate Corrective Action Plan (ICAP)*** or **Corrective Action Plan (CAP)** for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct **Auditing**, operational **Monitoring**, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an **ICAP** or **CAP** response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved **ICAP** or **CAP** response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's **ICAP** or **CAP** request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's **ICAP**, or **CAP**, request may lead to further action. CalOptima may impose **Sanctions** for the underlying non-compliant performance that gave rise to the **ICAP** or **CAP** request, or the failure to develop, submit, and meet the requirements of the **ICAP** or **CAP** request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

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

III. PROCEDURE

A. Basis for an **ICAP** or **CAP**

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, **Audit**s, and conduct ongoing **Monitoring** and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an **ICAP**/**CAP** request as a result of **Audit**s conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an **ICAP**/**CAP** request as a result of an **ICAP**/**CAP** request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an **ICAP**, or **CAP** request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an **ICAP** or **CAP** potentially warrants **Employee** disciplinary action.

B. **ICAP** and **CAP** Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized **ICAP** and **CAP** request template.

2. Non-compliance with specific requirements that have the potential to cause significant **Member** harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an **ICAP** response.

    a. If the finding requires an **ICAP** request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the **ICAP** request.

    b. The internal department or FDR shall provide a written response within three (3) business days of receiving an **ICAP** request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the **ICAP** response, the internal department or FDR is required to resolve the issue in a manner and timeframe deemed appropriate by CalOptima's Office of Compliance.

3. A **CAP** request is the result of material non-compliance with specific requirements that does not rise to the level of an **ICAP** request.

    a. The internal department or FDR is required to respond to the **CAP** request within fourteen (14) calendar days. CalOptima's Compliance Officer or **Designee** may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the **CAP** response, the internal department or FDR is required to resolve the issue in a manner and timeframe deemed appropriate by CalOptima's Office of Compliance.

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4. An **ICAP** or **CAP** response shall include the following elements:

    a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

    b. Steps taken to resolve the deficiency;

    c. Steps taken to avoid reoccurrence;

    d. Method for implementation and completion of **ICAP** response or **CAP** response;

    e. Individual(s) responsible for implementation of the **ICAP** response or **CAP** response;

    f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

    g. **ICAP** response or **CAP** response completion date(s), as applicable.

C. Unacceptable Resolution to an **ICAP** or **CAP**

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

    a. A summary of previous outreach and required action(s);

    b. An explanation of why that the resolution was not acceptable, or why a response was not received;

    c. A revised response timeline of two (2) business days for an **ICAP**;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or **Designee**.

    d. A revised response timeline of five (5) business days for a **CAP**;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or **Designee**.

    e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

    f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their **Designee**; and

    g. Possibility of referral to the **Audit & Oversight Committee** and the Compliance Committee.

D. Acceptable Resolution with **ICAP** or **CAP** Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an **ICAP** or **CAP** response requires **Monitoring** or a focused **Audit**, the **ICAP** or

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CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if **Monitoring** or a focused **Audit** is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or **Designee**, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

a. An acknowledgement of acceptance;

b. A description of follow up actions which shall include, but is not limited to:

i. Submission of finalized documentation; and/or

ii. Focused **Audit**, as described in Section III.E. of this Policy; and/or

iii. **Monitoring**, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or **Designee**, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

a. An acknowledgement of closure;

b. The effective date of closure; and

c. Consequences of repeat deficiencies.

E. Focused **Audit**s

1. CalOptima's Office of Compliance may conduct a focused **Audit** of an internal department or FDR to confirm implementation of the accepted **ICAP** or **CAP** response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, **Audit** period, and **Audit** deliverables that shall be required to complete the focused **Audit**.

3. CalOptima's Office of Compliance may continue to Monitor and/or **Audit** an internal department or FDR for performance of issues and/or functions related to the **ICAP** or **CAP** request.

F. **Monitoring** Period

1. CalOptima's Office of Compliance may conduct **Monitoring** of the internal department's or FDR's resolution to confirm implementation of the accepted **ICAP** or **CAP** response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined timeframe, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, **Monitoring** period, and deliverables that shall be required to complete the **Monitoring**.

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4. CalOptima's Office of Compliance may continue to **Monitor** and/or **Audit** an internal department's or FDR's performance of issues and/or functions related to the **ICAP** or **CAP** request.

G. Failure to Maintain Adequate Resolution

1. If during the **Monitoring** period or the focused **Audit** the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance may issue the internal department or FDR an **ICAP** or **CAP** request, as appropriate.

2. If an **ICAP** request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or **Designee**.

3. The **ICAP** request shall require the information as described in Section III.B.4. of this Policy.

H. **ICAP** and **CAP** Tracking and Reporting

1. CalOptima's Office of Compliance shall track all **CAP** and **ICAP** requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all **CAP/ICAP** requests to the **Audit & Oversight Committee** and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance issues an **ICAP** request with respect to the CalOptima Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager for Medi-Cal within three (3) business days of issuance.

4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the **Audit & Oversight Committee** and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
H. Medicare Managed Care Manual, Chapter 21

FOR 2017 PREVIEW

I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 08/02/18: Regular Meeting of the CalOptima Board of Directors
C. 12/07/17: Regular Meeting of the CalOptima Board of Directors
D. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities 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.
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.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	An enrollee-beneficiary of a CalOptima program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

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Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima's Office of Compliance is responsible for completing all cells in blue.

Responsible Party (CalOptima or Delegated Entity)		**Case #**	
		CAP Type: Immediate (ICAP) or Standard (CAP)	
Department (if applicable)		**Date CAP Sent by CalOptima**	
Date of Incident		**Date CAP Due to CalOptima**	
Investigator Name		**CAP Submitted By**	
Line of Business		**Date CAP Submitted**	

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima: Red)	Responsible Person/Contact Information	Implementation Date	CAP Status
1	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1) What is the root cause of the deficiency?** **2) What step(s) have been taken to resolve the deficiency?** **3) What control(s) have been implemented to ensure this deficiency does not reoccur?**			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima's Office of Compliance is responsible for completing all cells in blue.

		4) How will CAP be measured and monitored to close CAP?			
Monitoring Method(s) and Result				**Monitoring Status**	

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima: Red)	Responsible Person/Contact Information	Implementation Date	CAP Status
2	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1) What is the root cause of the deficiency?** **2) What step(s) have been taken to resolve the deficiency?** **3) What control(s) have been implemented to ensure this deficiency does not reoccur?**			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima's Office of Compliance is responsible for completing all cells in blue.

		4) How will CAP be measured and monitored to close CAP?			
Monitoring Method(s) and Result				**Monitoring Status**	

CAP Attestation:

I, _____ [NAME/TITLE] hereby have the authority to attest that the CAP(s), and subsequent remediation, as stated above, accurately reflect _____ [BUSINESS OWNER/DELEGATE] plan to remediate and execute the above referenced area(s) of non compliance.

Generated by:
(Responsible Party) _____ _____
Name, Title Signature Date

Approved by: _____ _____
(CalOptima) Name, Title Signature Date

Policy ~~#~~:	HH.2014Δ
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance

CEO Approval: Michael Schrader

Effective Date:	08/01/08
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~

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

~~*Board Approved Policy*~~

FOR 20191205BOD REVIEW

I. PURPOSE

This policy establishes a **Compliance Program*** to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

II. POLICY

A. CalOptima shall establish a written **Compliance Program**, in accordance with applicable regulatory and contractual requirements.

B. CalOptima's **First Tier, Downstream, and Related Entities (FDRs)** shall, at a minimum, develop a written **Compliance Program**, in accordance with this P~~p~~olicy.

C. CalOptima shall revise and update the **Compliance Program**, including the **Compliance Plan**, and all applicable CalOptima policies, as changes occur in CalOptima's needs, regulatory requirements, and applicable laws.

D. The CalOptima **Board of Directors** is responsible for overseeing the implementation and effectiveness of the **Compliance Program**, and approving the **Compliance Plan** and **Code of Conduct**.

E. The **Compliance Officer**, in conjunction with the **Compliance Committee**, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the **Board of Directors** on a periodic basis.

F. The **Compliance Officer**, in conjunction with the **Compliance Committee**, may update and make minor, non-substantive revisions to the **Compliance Plan** without the need to obtain **Board of Directors** approval.

G. CalOptima **Employees**, members of the **Governing Body**, and **FDRs**, shall comply with the **Compliance Program**.

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

Back to Agenda

III. PROCEDURE

A. The Office of Compliance shall recommend revisions to the **Compliance Plan**, **Code of Conduct**, and related policies and procedures, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima operations, or as otherwise indicated to meet the needs of **Members**.

B. The **Compliance Officer** shall submit recommended revisions to the **Compliance Plan** and **Code of Conduct**, to the **Compliance Committee** for review and approval.

C. Upon the **Compliance Committee's** approval, the **Compliance Officer** shall present substantive revisions to the **Compliance Plan** and/or **Code of Conduct** to the **Board of Directors** for approval and adoption into the **Compliance Program**. Minor non-substantive revisions, specifically the correction of typographical or formatting errors, to the **Compliance Plan** may be implemented without the need to obtain **Board of Directors** approval.

IV. ATTACHMENT(S)

A. CalOptima Compliance Plan
B. FDR Compliance Attestation

V. REFERENCE(S)

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Office of Inspector General Guidelines for Operating an Effective Compliance Program
J. Title 42, Code of Federal Regulations (CFR.), §§422.503, 423.504
K. Title 42, Code of Federal Regulations (CFR), §438.608(a)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/12/2013	Department of Health Care Services (DHCS)

~~A. 07/12/13: Department of Health Care Services~~

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Board of Directors

~~A. 12/06/18: Regular Meeting of the CalOptima Board of Directors~~

FOR 2019 1205 BOD REVIEW

~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors~~
~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors~~

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	06/01/2005	MA.9101	Compliance Program	OneCare
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014Δ	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	06/01/2013	MA.9101	Compliance Program	OneCare
Revised	06/01/2014	MA.9101	Compliance Program	OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE

FOR 20191205BOD REVIEW

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, the Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities.
Governing Body	The Board of Directors of CalOptima.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

FOR 2019 12 05 BOD REVIEW

Policy:	HH.2014Δ
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	08/01/08
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

FOR 20191205BOD REVIEW

I. PURPOSE

This policy establishes a **Compliance Program*** to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

II. POLICY

A. CalOptima shall establish a written **Compliance Program**, in accordance with applicable regulatory and contractual requirements.

B. CalOptima's **First Tier, Downstream, and Related Entities (FDRs)** shall, at a minimum, develop a written **Compliance Program**, in accordance with this Policy.

C. CalOptima shall revise and update the **Compliance Program**, including the **Compliance Plan**, and all applicable CalOptima policies, as changes occur in CalOptima's needs, regulatory requirements, and applicable laws.

D. The CalOptima **Board of Directors** is responsible for overseeing the implementation and effectiveness of the **Compliance Program**, and approving the **Compliance Plan** and **Code of Conduct**.

E. The **Compliance Officer**, in conjunction with the **Compliance Committee**, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the **Board of Directors** on a periodic basis.

F. The **Compliance Officer**, in conjunction with the **Compliance Committee**, may update and make minor, non-substantive revisions to the **Compliance Plan** without the need to obtain **Board of Directors** approval.

G. CalOptima **Employees**, members of the **Governing Body**, and **FDRs**, shall comply with the **Compliance Program**.

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

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III. PROCEDURE

A. The Office of Compliance shall recommend revisions to the **Compliance Plan**, **Code of Conduct**, and related policies and procedures, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima operations, or as otherwise indicated to meet the needs of **Members**.

B. The **Compliance Officer** shall submit recommended revisions to the **Compliance Plan** and **Code of Conduct**, to the **Compliance Committee** for review and approval.

C. Upon the **Compliance Committee's** approval, the **Compliance Officer** shall present substantive revisions to the **Compliance Plan** and/or **Code of Conduct** to the **Board of Directors** for approval and adoption into the **Compliance Program**. Minor non-substantive revisions, specifically the correction of typographical or formatting errors, to the **Compliance Plan** may be implemented without the need to obtain **Board of Directors** approval.

IV. ATTACHMENT(S)

A. CalOptima Compliance Plan
B. FDR Compliance Attestation

V. REFERENCE(S)

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Office of Inspector General Guidelines for Operating an Effective Compliance Program
J. Title 42, Code of Federal Regulations (CFR.), §§422.503, 423.504
K. Title 42, Code of Federal Regulations (CFR), §438.608(a)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/12/2013	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

FOR 2019 1205 BOD REVIEW

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2005	MA.9101	Compliance Program	OneCare
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014Δ	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	06/01/2013	MA.9101	Compliance Program	OneCare
Revised	06/01/2014	MA.9101	Compliance Program	OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE

FOR 20191205ROD REVIEW

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, the Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities.
Governing Body	The Board of Directors of CalOptima.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

FOR 2019 12 05 BOD REVIEW

Orange County Health Authority
dba CalOptima

~~2019~~

2020 Compliance Plan

(Revised December ~~2018)~~2019)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, **Program of All-Inclusive Care for the Elderly (PACE)**, **Multipurpose Senior Services Program (MSSP)**, and other **CalOptima** ~~***programs***~~**Programs**.*

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's **First Tier**, **Downstream**, and **Related Entities** (**FDRs**), such as ~~***health networks***~~**Health Networks**, physician groups, ~~***participating providers***~~**Participating Providers, and** ~~***suppliers***~~~~, pharmacy benefit manager~~**Suppliers, Pharmacy Benefit Manager (PBM)**, and consultants. The term **FDR** is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the **Centers for Medicare & Medicaid Services** (**CMS**) and the **Department of Health Care Services** (**DHCS**). Such persons/entities, referred to as **FDR** herein, include those that directly contract with CalOptima and those that are **Downstream** or **Related Entities** (i.e., subcontracts) with CalOptima's **First Tier Entities**.

CalOptima has developed a comprehensive **Compliance Program** applicable to all of CalOptima's programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "**OneCare**"), its Medicare-Medicaid Plan (MMP referred to as "**OneCare Connect**"), **PACE**, and **MSSP**. The **Compliance Program** incorporates all ~~of the~~ elements of an effective **Compliance Program** as recommended by the **Office of the Inspector General** (**OIG**) and required by **CMS** regulations. The **Compliance Program** is continually evolving and may be modified and enhanced based on compliance ~~monitoring~~**Monitoring** and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that **CalOptima Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** conduct themselves in accordance with the requirements of CalOptima's **Compliance Program**.

B. THE COMPLIANCE PLAN

This **Compliance Plan** sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The **Compliance Plan** addresses the fundamental elements of an effective **Compliance Program** and identifies how CalOptima is implementing each of the fundamental elements of an effective **Compliance Program** in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the **Compliance Plan** is designed to provide guidance and to ensure that CalOptima's operations and the practices of its **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** comply with contractual requirements, ethical standards, and applicable law.

This **Compliance Plan** is adopted by the **Governing Body**. It was developed and is managed by the **Executive Director of Compliance** (hereinafter referred to ~~hereinafter~~ as the "**Compliance Officer**") with the **Compliance Committee**. ~~Because~~Due to the dynamic nature of the complex laws governing CalOptima and its programs ~~are constantly evolving~~, the **Compliance Plan** may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board ~~***members, employees***~~**Members, Employees**, and **FDRs** are expected to review and adhere to the requirements and standards set forth in the **Compliance Plan**, the **Code of Conduct**, and all related ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, as may be amended. Furthermore, **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a **Board** ~~***member, employee***~~**Member, Employee**, and/or **FDR** has/have any questions about the application, or implementation, of this **Compliance Plan**, or questions related to the **Code of Conduct** or CalOptima ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, he or she should seek guidance from the **Compliance Officer** and/or the CalOptima Office of Compliance.

I.WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**, CalOptima develops, maintains, and distributes its written standards in the form of this **Compliance Plan**, a separate **Code of Conduct**, and written ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**.

a. Compliance Plan

As noted above, this **Compliance Plan** outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to **CalOptima Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**. This **Compliance Plan** also includes a comprehensive section articulating CalOptima's commitment to preventing **Fraud**, **Waste**, & **Abuse** (**FWA**), and setting forth guidelines and procedures designed to detect, prevent, and remediate **FWA** in the administration of **CalOptima** ~~*programs*~~**Programs**. The **Compliance Plan** is available on CalOptima's external website for **Board** ~~*members*~~**Members** and **FDRs**, as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all ~~*employees*~~**Employees**.

b. Policies and Procedures

CalOptima also developed written ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** to address specific areas of CalOptima's operations, compliance activities, and **FWA** prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These ~~policies~~**Policies and Procedures** are designed to provide guidance to **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** are expected to be familiar with the ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The **Compliance Officer**, or his/her ~~*designee*~~**Designee**, will ensure that **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

The ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to CalOptima's ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**. **Policies and** ~~*procedures*~~**Procedures** are available on CalOptima's internal website and Compliance 360~~,~~ (C360), a separate web portal accessible to **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**. **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** receive notice when ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** are updated via a monthly memorandum.

c. Code of Conduct

Finally, the **Code of Conduct** is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the **Code of Conduct** is to articulate compliance expectations and broad principles that guide **CalOptima Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** in conducting their business activities in a professional, ethical, and lawful manner. The **Code of Conduct** is a separate document from the **Compliance Plan** and can be found in Appendix A. The **Code of Conduct** is approved by ~~CalOptima's~~the **CalOptima Board of Directors** and distributed to **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** upon appointment, hire, or the commencement of the contract, and annually thereafter. New **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs** are required to sign an attestation acknowledging receipt and review of the **Code of Conduct** within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the **Compliance Program** requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by ~~CalOptima's~~the **CalOptima Board**, the **Compliance Officer**, the **Compliance Committee**, the **Audit & Oversight Committee**, and ~~***senior management***~~**Executive Staff**.

a. Governing Body

The **CalOptima Board of Directors**, as the **Governing Body**, is responsible for approving, implementing, and ~~monitoring~~**Monitoring** a **Compliance Program** governing CalOptima's operations. The **CalOptima Board** delegates the **Compliance Program** oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the **Compliance Officer**. The **Compliance Officer** is an ~~***employee***~~**Employee** of CalOptima, who handles compliance oversight and activities full-time. The **Compliance Officer**, in conjunction with the **Compliance Committee**, are both accountable for the oversight and reporting roles and responsibilities as set forth in this **Compliance Plan**. However, the **CalOptima Board** remains accountable for ensuring the effectiveness of the **Compliance Program** within CalOptima and ~~monitoring~~**Monitoring** the status of the **Compliance Program** to ensure its efficient and successful implementation.

To ensure the **CalOptima Board** exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's **Compliance Program**, the **CalOptima Board**:

- Understands the content and operation of CalOptima's **Compliance Program**;
- Approves the **Compliance Program**, including this **Compliance Plan** and the **Code of Conduct**;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the **Compliance Program** outcomes, including, but not limited to, results of internal and external ~~***audits***~~**Audits**;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the **Compliance Program**;
- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, **Corrective Action Plans**, Warning Letters, and/or ~~***sanctions***~~**Sanctions**;
- Receives regularly scheduled, periodic updates from CalOptima's **Compliance Officer** and **Compliance Committee**, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the **Compliance Program**.

The **CalOptima Board** reviews the measurable indicators of an effective **Compliance Program** and remains appropriately engaged in overseeing its efficient and successful implementation; however, the **CalOptima Board** delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The **Executive Director of Compliance** serves as the **Compliance Officer** who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the **Compliance Program**. The **Compliance Officer** reports directly to the CEO and the **Compliance Committee** on the activities and status of the **Compliance Program**. The **Compliance Officer** has authority to report matters directly to the **CalOptima Board** at any time. Furthermore, the **Compliance Officer** ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The **Compliance Officer** interacts with the **CalOptima Board**, CEO, CalOptima's ~~executive~~Executive Staff and departmental ~~management~~Management, **FDRs**, legal counsel, state and federal representatives, and others as required. In addition, the **Compliance Officer** supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, **FDR** and internal oversight, ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, and training on compliance activities.

The **CalOptima Board** delegates the following responsibilities to the **Compliance Officer**, and/or his/her ~~***designee***~~**Designee(s)**:

- Chair the **Compliance Committee**, which shall meet no less than quarterly and assists the **Compliance Officer** in fulfilling his/her responsibilities;
- Ensure that the **Compliance Program**, including this **Compliance Plan** and ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs**, as appropriate;
- Oversee and monitor the implementation of the **Compliance Program**, and provide regular reports no less than quarterly to the **CalOptima Board** and CEO summarizing all efforts, including, but not limited to, the **Compliance Committee**'s efforts to ensure adherence to the **Compliance Program**, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and ~~***audit***~~**Audit** activities;
- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential **FWA** received from any source through any reporting method;
- Design, coordinate, and/or conduct regular internal ~~***audits***~~**Audits** to ensure the **Compliance Program** is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of **Compliance Program** activities for each of CalOptima's programs, and regularly report CalOptima's progress in implementing those plans to the appropriate **Board** ~~Committee~~ committee and/or to the **Board of Directors**;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or **FWA** issues, including facilitating any documentation or procedural requests by such agency(s);
- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., **DHCS** and **CMS**) and consult with legal counsel, as necessary;

- Create and coordinate educational training programs and initiatives to ensure that the **CalOptima Board**, ~~***employees***~~**Employees**, and **FDRs** are knowledgeable about CalOptima's **Compliance Program**, including the **Code of Conduct**, ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, and all current and emerging applicable statutory and regulatory requirements;
- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate **Corrective Action Plans**, ~~***sanctions***~~**Sanctions**, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and **FDRs** to ensure ~~exclusion~~**Exclusion** and ~~preclusion~~**Preclusion** screening (including through the **OIG List of Excluded Individuals and Entities (LEIE)**, **General Services Administration (GSA) System for Award Management (SAM)**, ~~and~~ **Medi-Cal Suspended & Ineligible (S&I) Provider List**, and the **CMS Preclusion List**) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The **Compliance Committee**, chaired by the **Compliance Officer**, is composed of CalOptima's ~~***senior management***~~**Executive Staff** and operational staff, as designated by the CEO. The members of the **Compliance Committee** serve at the discretion of the CEO and may be removed, or added, at any time. The role of the **Compliance Committee** is to implement and oversee the **Compliance Program** and to participate in carrying out the provisions of this **Compliance Plan**. The **Compliance Committee** meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the **Compliance Program**.

The **CalOptima Board** delegates the following responsibilities to the **Compliance Committee**:

- Maintain and update the **Code of Conduct** consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the **CalOptima Board**;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of **Compliance Committee** meetings reflecting reports made to the **Compliance Committee** and the **Compliance Committee's** decisions on the issues raised (subject to all applicable privileges);
- Review and **Monitor** the effectiveness of the **Compliance Program**, including **Monitoring** key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the **Compliance Officer** to ensure the adequacy of the **Compliance Program**;
- Review, approve, and/or update ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** to ensure the successful implementation and effectiveness of the **Compliance Program** consistent with regulatory, legal, and contractual requirements;
- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the **Compliance Officer** accordingly;

- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of ~~*monitoring*~~**Monitoring** and ~~auditing~~**Auditing** of areas in which CalOptima is at risk of program non-compliance and/or potential **FWA**, and ensure **CAPs** and **ICAPs** are implemented and **Monitored** for effectiveness;
- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its **FDRs** conduct activities and operations in compliance with the applicable ~~law~~laws and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the **CalOptima Board of Directors**.

d. Audit & Oversight Committee (AOC)

The **Audit & Oversight Committee** (**AOC**) is a subcommittee of the **Compliance Committee** and is co-led by the Director(s) of Audit & Oversight. The **AOC** is responsible for overseeing the delegated and internal activities of CalOptima. The **Compliance Committee** has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee. In addition to the monthly scheduled meetings, the **AOC** may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the **AOC** are approved by the majority of a quorum of the **AOC**. A quorum is defined as one (1) over fifty percent (50%). **AOC** may approve and/or implement **Corrective Action Plans** (**CAPs**); however, recommendations for **FDR** ~~sanctioning~~**Sanctions** and/or de-~~*delegation*~~**Delegation** are submitted to the **Compliance Committee** for final approval. The **AOC** also contributes to external reviews and accreditation ~~*audits*~~**Audits**, such as the **National Committee for Quality Assurance** (**NCQA**).

Responsibilities of the **Audit & Oversight Committee** with regard to **FDRs** include:

- Annual review, revision, and approval of the ~~*audit*~~**Audit** tools;
- Review findings of the~~-~~ readiness assessment to evaluate a potential **FDR**'s ability to perform the delegated function(s);
- Review and approve potential **FDR** entities for ~~*delegation*~~**Delegation** of functions;
- Ensure written agreements with each delegated **FDR** clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and ~~monitoring~~**Monitoring** of **FDR** performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite ~~*audit*~~**Audit**;
- Ensure all **Downstream** and **Related Entities** are ~~monitored~~**Monitored** in accordance with CalOptima oversight procedures;
- Ensure that formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage **Corrective Action Plans** (**CAPs**) for compliance issues;
- Propose ~~*sanctions*~~**Sanctions**, subject to the **Compliance Committee's** approval, if an **FDR's** performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of ~~*delegation*~~**Delegation**, to the **Compliance Committee** for unresolved issues of compliance.

Responsibilities of the **Audit & Oversight Committee** ~~with regard to~~regarding internal business functions include:

- Annual review, revision, and approval of the ~~audit~~**Audit** work plan and ~~***audit***~~**Audit** tools;
- Conduct formal, ongoing evaluation and ~~monitoring~~**Monitoring** of internal business areas' performance and compliance through review of periodic reports submitted, ongoing ~~monitoring~~**Monitoring**, and findings of the annual ~~***audit***~~**Audit**;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage **Corrective Action Plans** (**CAPs**) for compliance issues.

~~**e. Senior Management**~~

- Initiate and manage other disciplinary actions (e.g., sanctions, de-delegation) for compliance issues.

e. Executive Staff

The CEO and ~~other executive management~~**Executive Staff** of CalOptima shall:

- Ensure that the **Compliance Officer** is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective **Compliance Program**;
- Receive periodic reports from the **Compliance Officer** of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including ~~***audit***~~**Audit** findings, ~~notices~~Notices of ~~non-compliance~~Non-Compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III. TRAINING

Education and training are critical elements of the **Compliance Program**. CalOptima requires that all **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's **Code of Conduct**, compliance obligations, ~~and~~ relevant laws, and **FWA**, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing ~~seniors~~**Seniors and** ~~people~~**People with** ~~disabilities~~**Disabilities (SPD)** and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the **Compliance Program**, and which courses are updated regularly to ensure that ~~*employees*~~**Employees** are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The **Compliance Officer,** or his/her ~~*designee*~~**Designee,** is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/**FDR's** completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The **Compliance Officer** and the CalOptima ~~management staff~~**Executive Staff** and **Management** are responsible for ensuring that **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's **Code of Conduct** to **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**. **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** are required to sign an attestation acknowledging receipt, review, and understanding of the **Code of Conduct** within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the **Code of Conduct** is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each individual's personnel file, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the **Compliance Program**; **FWA** training; **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the **Compliance Program** are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or **FWA** issues, along with CalOptima's policy on confidentiality, anonymity, and

non-retaliation for such reporting. CalOptima's **HIPAA** privacy and security training course covers the administrative, technical, and physical safeguards necessary to secure ~~***members'* protected health information~~**Members' Protected Health Information** **(PHI)** and ~~personally identifiable information~~**Personally Identifiable Information** **(PII)**.

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the **Compliance Program** requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each ~~***employee***~~**Employee**. **Board** ~~***members***~~**Members** and **FDRs** are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some **FDRs** may be exempt or deemed to have met the **FWA** training and education requirement if the **FDR** has met the **CMS** requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the **Compliance Program**. These training opportunities are available to ~~***managers***~~**Managers** and ~~***employees***~~**Employees** depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing ~~***managers***~~**Managers** the tools and resources to train and share the information with ~~***employees***~~**Employees** in their respective departments. If additional training related to **FWA** is required, the **Compliance Officer,** or his/her ~~***designee***~~**Designee,** will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** governing the **Compliance Program** and pertinent to their respective roles and responsibilities. **Employees** may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board ~~***members***~~**Members** receive a copy of the **Compliance Plan**, **Code of Conduct**, and ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the **CalOptima Board**. **Board** ~~***members***~~**Members** may receive additional compliance training related to the **CalOptima Board**'s role in overseeing and ensuring organizational compliance with CalOptima's **Compliance Program**.

The **Code of Conduct** and ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to **FDRs** upon commencement of the **FDR** contract. **FDRs** are required to disseminate copies of the **Code of Conduct** and ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** to their ~~***employees***~~**Employees**, agents, and/or **Downstream Entities**. CalOptima may also develop compliance training and education presentations and/or roundtables for specified **FDRs**.

IV.LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the **Compliance Program** and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**, contact information for the **Compliance Officer**, relevant federal and state ~~*fraud*~~**Fraud** alerts and policy letters, pending/new legislation reports, and advisory bulletins from the **Compliance Officer** to **CalOptima Board** ~~*members, employees*~~**Members, Employees**, **FDRs**, and ~~*members*~~**Members**, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the **CalOptima Board**, **FDRs**, ~~*employees,*~~ **Employees**, and individual CalOptima departments, and ~~*members.*~~ **Members.**
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs**, which contains CalOptima's updated ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to **Board** ~~*members, employees*~~**Members, Employees**, **FDRs**, and ~~*members*~~**Members**.
- Electronic Mail – The CEO, **Compliance Officer**, or their respective ~~*designee*~~**Designee**, periodically sends out email communications and/or alerts to **Board** ~~*members, employees,*~~**Members, Employees**, and **FDRs**, and/or ~~*members*~~**Members**, as applicable.
- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to ~~*employees*~~**Employees**.
- CalOptima's Compliance Internal Website – The Office of Compliance maintains an internal department website accessible to CalOptima ~~*employees*~~**Employees** to communicate different Compliance initiatives, notices, key documents and forms, and updates to the **Compliance Program**, **Code of Conduct**, and/or ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and **FWA** throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima ~~*employees*~~**Employees**.
- Written Reports – The **Compliance Officer**, in coordination with the CEO and **Compliance Committee**, prepares written ~~monthly~~ reports~~.~~, no less than quarterly, concerning the status of the **Compliance Program** to be presented to the **CalOptima Board**.
- Direct Contact with the **Compliance Officer** - **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** can obtain additional compliance information directly from the **Compliance Officer**. Any questions, which cannot be answered by the **Compliance Officer**, shall be referred to the **Compliance Committee**.

b. Reporting Mechanisms

CalOptima Board ~~*members, employees*~~**Members, Employees**, and **FDRs** have an affirmative duty and are directed in CalOptima's **Code of Conduct** and ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by **Board** ~~*members, employees*~~**Members, Employees**, and/or

FDRs to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an **FDR** contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or **FWA** incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and **FWA** issues are also provided to **Board** ~~*members*~~, ~~*employees*~~**Members, Employees**, **FDRs**, and ~~*members*~~**Members** in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or **FWA**.

Upon receipt of a report through one (1) of the listed mechanisms, the **Compliance Officer**, or his/her ~~*designee*~~**Designee**, shall follow appropriate ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** to promptly review, investigate, and resolve such matters. The **Compliance Officer,** or his/her ~~*designee*~~**Designee**, shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to ~~a Supervisor~~Management or ~~Manager~~Executive Staff*

CalOptima ~~*employees*~~**Employees** are encouraged to contact their immediate ~~*supervisor*~~,**Management** or ~~*manager*~~,**Executive Staff** when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. ~~The *supervisor*~~,**Executive Staff** or ~~*manager*~~,**Management** will promptly escalate the report to the **Compliance Officer** for further investigation and reporting to the CalOptima **Compliance Committee**. If an ~~*employee*~~**Employee** is concerned that his/her ~~*supervisor*~~**Management** or ~~*manager*~~**Executive Staff** did not adequately address his/her report or complaint, the ~~*employee*~~**Employee** may go directly to the **Compliance Officer**, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with ~~Spanish and English capability~~multilingual support, in which CalOptima may receive anonymous issues on a confidential basis. **Members** are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or **FWA** issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all **Board** ~~*members*~~,

~~*employees*~~**Members, Employees**, **FDRs**, and ~~*members*~~**Members**. **Members** also have access to the **Compliance Officer** through the Compliance and Ethics Hotline and/or the right to contact the **OIG** Compliance Hotline (1-800-447-8477) directly.

3. *Report Directly to the Compliance Officer*

The **Compliance Officer** is available to receive reports of suspected or actual compliance violations, or **FWA** issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from **Board** ~~*members, employees*~~**Members, Employees**, **FDRs** and ~~*members*~~**Members**. The **Compliance Officer** may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. **FDRs** are generally contractually obligated to report suspected ~~*fraud*~~**Fraud** and ~~*abuse*~~**Abuse** to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or **FWA**, issues in good faith. This non-retaliation policy extends to reports received from **FDRs** and ~~*members*~~**Members**. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic ~~member~~**Member** notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the **Compliance Officer** will review and enforce disciplinary and/or other **Corrective Action Plans** for violations, as appropriate, with the approval of the **Compliance Committee**.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board ~~*members, employees*~~**Members, Employees**, and **FDRs** are provided copies of CalOptima's **Code of Conduct** and the **Compliance Plan** and have access on CalOptima's internal and external website to applicable ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards and Office of Compliance Policies addressing **Corrective Action Plans** and ~~*sanctions*~~**Sanctions**. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board ~~*members, employees*~~**Members, Employees**, and **FDRs** are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the **Compliance Program** documents and related ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**, including CalOptima Policy GA.8022: Performance and Behavior Standards, as applicable. **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's **Compliance Program** and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in **Federal and/or State** ~~*health care programs*~~**Health Care Programs**;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures** and/or contracts; or
- Failure to report violations or suspected violations of the **Compliance Program**, or applicable laws, or to report suspected or actual **FWA** issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates **HIPAA** and other privacy laws and/or CalOptima's **HIPAA** privacy and security policies, including actions that harm the privacy of ~~*members*~~**Members**, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the **Compliance Program** shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, ~~*sanctions*~~**Sanctions**, and/or termination, depending on the nature and severity of the conduct, or behavior. **Board** ~~*members*~~**Members** may be subject to removal, ~~*employees*~~**Employees** are subject to discipline, up to and including termination, and **FDRs** may be sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative ~~*sanctions*~~**Sanctions** and/or penalties. Further violations could lead to suspension,

~~preclusion~~**Preclusion**, or ~~exclusion~~**Exclusion**, from participation in **Federal and/or State** ~~***health care programs***~~**Health Care Programs**.

CalOptima ~~***employees***~~**Employees** shall be evaluated annually based on their compliance with CalOptima's **Compliance Program**. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** are identified through a combination of activities: risk assessments, **Audit & Oversight Committee** and **Compliance Committee** discussions and decisions, and internal and external reporting. Through ~~monitoring, auditing~~**Monitoring, Auditing**, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The **Compliance Officer,** or his/her ~~***designee***~~**Designee,** will collaborate with the **Compliance Committee** to identify areas of focus for ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** potential non-compliant activity and **FWA** issues. A **Compliance Risk Assessment** will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of **FDRs**. Operations and processes will be evaluated based on: (1) deficiencies found by ~~regulatory agencies~~**Regulatory Agencies**; (2) deficiencies found by internal and external ~~***audit***~~**Audit** and ~~***monitoring***~~**Monitoring** reports; (3) the institution of new or updated ~~procedures~~**Policies and Procedures**; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by **CMS** and the **OIG** Work Plan shall be used as resources to evaluate operational risks.

The **Compliance Officer,** or his/her ~~***designee***~~**Designee,** will work with the Chief Operating Officer, or his/her ~~***designee***~~**Designee**, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and ~~auditing~~**Auditing**. Those operational areas determined to be high risk may be subject to more frequent ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing**, as well as additional reporting requirements. The risk assessment process will be managed by the **Compliance Officer**, or his/her ~~***designee***~~**Designee**, and presented to the **AOC**, and subsequently to the **Compliance Committee**, for review and approval. **Monitoring** plans will be developed in collaboration with the operational areas, and focused ~~***audits***~~**Audits** may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine ~~auditing~~**Auditing** and ~~***monitoring activities***~~**Monitoring Activities** to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima ~~***policies***~~**Policies** **and** ~~***procedures***~~**Procedures** to protect against non-compliance and potential **FWA** in **CalOptima** ~~***programs***~~**Programs**. CalOptima and **FDRs** shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. **Monitoring** ~~***activities***~~**Activities** are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An ~~***audit***~~**Audit** is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a ~~particular~~ set of standards (e.g., ~~***policies***~~**Policies** **and** ~~***procedures***~~**Procedures**, laws, and regulations) used as base measures. As part of the ~~monitoring~~**Monitoring** process, CalOptima has created a dashboard, which is a

~~monitoring~~**Monitoring** tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with ~~monitoring~~**Monitoring** operations and outcomes and to identify areas in need of targeted ~~auditing~~**Auditing** on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** work plans. **Monitoring** and ~~auditing~~**Auditing** work plans are used to detect potential areas of risk and/or non-compliant activity. The ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** work plans are subject to daily updates and additions, and are therefore, working documents. The **Compliance Officer**, or his/her ~~***designee***~~**Designee,** in collaboration with the **AOC** and **Compliance Committee**, develops the ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** work plans to address the risks associated with each of **CalOptima's** ~~***programs***~~**Programs**.

The **Compliance Officer,** or his/her ~~***designee***~~**Designee,** will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate ~~auditing~~**Auditing** and ~~***monitoring activities***~~**Monitoring Activities**. **Audits** for each operational area will be conducted throughout the year consistent with the ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** work plans. The **Compliance Officer**, or his/her ~~***designee***~~**Designee,** will coordinate the ~~***audits***~~**Audits** with internal audit staff, and, in some cases, with the assistance from an outside vendor. **Audit** methodologies shall be consistent with regulatory and **NCQA** requirements and standards. All ~~***audits***~~**Audits** will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the ~~***audit***~~**Audit** review is completed, the ~~***audit team***~~Audit & Oversight teams will communicate the results to the **Compliance Officer** and propose follow up corrective action(s), if necessary. The **Compliance Officer,** or his/her ~~***designee***~~**Designee,** will provide reports to the CEO and the **Compliance Committee** concerning the results of the ~~***audits***~~**Audits**. The **AOC** reports to the **Compliance Officer** and the **Compliance Committee** on ~~***audits***~~**Audits** that involve **FDRs** as discussed below. If **FWA** issues are identified during an ~~***audit***~~**Audit**, the matter will be further investigated and resolved in a timely manner. In addition, an ~~***audit***~~**Audit** of the **Compliance Program** and its effectiveness should occur at least annually, and the results shall be reported to the **CalOptima Board**.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to **CMS**, **DHCS**, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** process of **FDRs** who perform delegated activities. The processes that CalOptima implements to oversee, ~~monitor~~**Monitor**, and ~~***audit***~~**Audit** **FDRs** are incorporated into CalOptima's written ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, including processes involving pre-contractual evaluations and ~~***audits***~~**Audits** of **First Tier Entities**. CalOptima may implement **Corrective Action Plans**, ~~***sanctions***~~**Sanctions**, and/or revoke its ~~***delegation***~~**Delegation** of duties (in a manner permitted under the contract) if CalOptima determines that an **FDR** is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The **Compliance Officer**, or his/her ~~***designee***~~**Designee**, determines the process for ~~monitoring~~**Monitoring** delegated **FDRs** and develops the annual ~~monitoring~~**Monitoring** and ~~***audit***~~**Audit** calendar in order to ~~validPate~~validate compliance with contractual standards and regulatory requirements. The **AOC** is responsible for overseeing all of the delegated activities and will review the readiness assessment, ensure the annual review of **FDRs** for delegated functions are

completed, conduct formal on-going evaluation of **FDR** performance and compliance, ensure **Downstream** and **Related Entities** are monitored, and impose **Corrective Action Plans** and/or ~~*sanctions*~~**Sanctions** if the **FDR**'s performance fails to meet statutory and contractual standards and requirements. The **AOC** may recommend termination of ~~*delegation*~~**Delegation** to the **Compliance Committee** for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or ~~*delegation*~~**Delegation** agreement with a potential **FDR**, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**, is completed to determine the ability of the potential **FDR** to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, **CMS**, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not ~~precluded~~**Precluded** on the **Preclusion List**, excluded in the **OIG List of Excluded Individuals/Entities (LEIE)**, the **General Services Administration (GSA) System of Award Management (SAM)**, or the ~~*DHCS*~~ **Medi-Cal Suspended & Ineligible (S&I) Provider** ~~Manual~~ **List** from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the **AOC** and subsequently the **Compliance Committee** for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the ~~*delegation*~~**Delegation** agreement specifies the activities CalOptima delegates to the **FDRs**, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and ~~*audits*~~**Audits**, and remedies, including disciplinary actions, available to CalOptima. Prior to any ~~*sub*~~**Sub-delegation** to any **Downstream** or **Related Entity**, a **First Tier Entity** must obtain approval from CalOptima. CalOptima determines who will directly monitor the **Downstream** or **Related Entity's** compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the **FDR** and their contractually delegated area(s). Furthermore, **FDRs** will be required to complete, sign, and return attestation forms confirming the **FDR**'s compliance with new hire and annual training and education requirements, which includes courses on general compliance and **FWA** as well as ~~exclusion~~**Exclusion** and ~~preclusion~~**Preclusion** screening and **FWA** reporting obligations.

3. *Annual Risk Assessment*

The **Compliance Officer**, or his/her ~~*designee*~~**Designee**, will ensure that an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate) to determine the **FDR's** vulnerabilities and high-risk areas. High-risk **FDRs** are those that are continually non-compliant or at risk of non-compliance based on identified gaps in

processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any **FDR** deemed high risk, or vulnerable, is presented to the **AOC** for suggested follow-up ~~*audit*~~**Audit**. **FDRs** determined to be high risk may be subjected to a more frequent ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing** schedule, as well as additional reporting requirements. The risk assessment process, along with reports from **FDRs**, will be managed by the **Compliance Officer**, or his/her ~~*designee*~~**Designee**, and presented to the **AOC** and subsequently to the **Compliance Committee** for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the **FDR's** ability to provide delegated services in accordance with contractual standards and applicable state, **CMS**, and accreditation requirements, as further detailed in CalOptima's ~~*policies*~~**Policies and** ~~*procedures*~~**Procedures**. CalOptima may conduct ~~*audits*~~**Audits** of **FDRs** at any time. Such ~~*audits*~~**Audits** may include an evaluation of the **FDR's** training and education program and materials covering general compliance and **FWA**, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk **FDRs**, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual ~~*audit*~~**Audit** calendar; however, CalOptima does not limit its ~~auditing~~**Auditing** schedule to only high-risk **FDRs**.

If CalOptima has reason to believe the **FDR's** ability to perform a delegated function is compromised, an additional focused ~~*audit*~~**Audit** may be performed. The **Compliance Officer,** or his/her ~~*designee*~~**Designee**, may also recommend focused ~~*audits*~~**Audits** upon evaluation of non-compliant trends or reported incidents. The results of these ~~*audits*~~**Audits** will be reported to the **AOC** and then to the **Compliance Committee**.

A focused ~~*audit*~~**Audit** may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or CalOptima's service level performance indicators;
- Failure to comply with a **Corrective Action Plan**;
- Reported or alleged ~~*fraud, waste*~~**Fraud, Waste**, and/or ~~*abuse*~~**Abuse**;
- Significant policy variations that deviate from the CalOptima or state, **CMS**, or accreditation requirements;
- Bankruptcy, or impending bankruptcy, which may impact services to ~~*members*~~**Members** (either suspected or reported);
- Sale, merger, or acquisition involving the **FDR**;
- Significant changes in the management of the **FDR**; and/or
- Changes in resources which impact CalOptima's and/or the **FDR's** operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The **Compliance Officer,** or his/her ~~*designee*~~**Designee**, shall submit regular reports of all monitoring, ~~*audit*~~**Audit**, and corrective action activities to the **Compliance Committee**. In instances where non-compliance is identified, a **Corrective Action Plan** shall be developed by the

FDR and reviewed and approved by the **Compliance Officer**, or his/her ~~*designee*~~**Designee**. Every **Corrective Action Plan** is presented to the AOC, in aggregate, with no less than quarterly updates, and recommendations for ~~review.~~escalation, as applicable. Supplemental and focused ~~*audits*~~**Audits** of **FDRs**, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement ~~*sanctions*~~**Sanctions** or require remediation by an **FDR** for failure to fulfill contractual obligations including development and implementation of a **Corrective Action Plan**. Failure to cooperate with CalOptima in any manner may result in termination of the ~~*delegation*~~**Delegation** agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's ~~auditing~~**Auditing** process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the ~~auditing~~**Auditing** processes, including ~~*policies*~~**Policies** **and** ~~*procedures*~~, ~~*audit*~~**Procedures, Audit** tools, and ~~*audit*~~**Audit** findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- The central database of all pending, active, and terminated **FDRs** to monitor and track functions, performance, and ~~*audit*~~**Audit** schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of ~~*audit*~~**Audit** tools;
- Implementation of a process for noticing **FDRs** and functional areas of **Corrective Action Plans**;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding ~~*delegation*~~**Delegation** standards, ~~auditing~~**Auditing**, and ~~monitoring~~**Monitoring** **FDR** performance; and/or
- Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of **FDR** performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight ~~*audits*~~**Audits** completed within twelve (12) months; and
- **Corrective Action Plans** (**CAPs**) completed within the established time frame.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's ~~*policies*~~**Policies** **and** ~~*procedures*~~**Procedures**, CalOptima performs **Participation Status Reviews** by ~~reviewing~~searching the **OIG –LEIE**, the **GSA–SAM**, the **DHCS Medi-Cal Suspended & Ineligible Provider Lists**, and the **CMS Preclusion List** upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure

Board ~~*members, employees*~~**Members, Employees**, and/or **FDRs** are not excluded, or do not become excluded or precluded from participating in **Federal and/or State** ~~*health care programs.*~~**Health Care Programs**. **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** are required to disclose their ~~*participation status*~~**Participation Status** as part of their initial appointment, employment, commencement of the contract and registration/application processes and when **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** receive notice of a suspension, ~~preclusion, exclusion~~**Preclusion, Exclusion**, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its **First Tier Entities** comply with **Participation Status Review** requirements with respect to their relationships with **Downstream Entities**, including without limitation, the delegated credentialing and re-credentialing processes.

The **Compliance Officer,** or his/her ~~*designee*~~**Designee,** will review reports from ~~*employees*~~**Employees** responsible for conducting the **Participation Status Reviews** to ensure ~~*employees*~~**Employees** record and maintain the results of the reviews and notices/disclosures. **Employees** shall immediately notify the **Compliance Officer**, or his/her **Designee,** of affirmative findings of a person, or entity's, failure to meet the **Participation Status Review** requirements. If CalOptima learns that any prospective, or current, **Board** ~~*member, employee*~~**Member, Employee**, or **FDR** has been proposed for ~~exclusion, excluded~~**Exclusion, Excluded**, or ~~precluded~~**Precluded**, CalOptima will promptly remove him/her/the **FDR** from **CalOptima's** ~~*programs*~~**Programs** consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of their suspension, ~~exclusion~~**Exclusion**, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the **CMS Preclusion List**, consistent with regulatory guidance, applicable policies, and/or contract terms. The **Compliance Officer,** or his/her ~~*designee*~~**Designee**, will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII.RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's **Compliance Program** and/or **FWA** issues, the **Compliance Officer,** or his/her ~~***designee***~~**Designee**, shall, upon promptly verifying the facts related to the violation or likely violation, notify the **Compliance Committee**, as appropriate. The **Compliance Committee** (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, ~~***sanctions***~~**Sanctions**, termination of any agreement and/or any other corrective action ~~(including repayment of ***overpayments***)~~ consistent with applicable ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures**, subject to consultation with legal counsel and/or notifying the **Governing Body**, as appropriate;
- Implementing education and training programs for **Board** ~~***members, employees***~~**Members, Employees**, and/or **FDRs**, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's **Compliance Plan**, **Code of Conduct**, and/or relevant ~~***policies***~~**Policies and** ~~***procedures*** in an effort~~**Procedures** to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the **Compliance Officer** and the **Compliance Committee** to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** after considering such recommendations. The **Compliance Officer**, or his/her ~~***designee***, shall~~**Designee**, may monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to **DHCS** Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning ~~***fraud***~~**Fraud** schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims activity indicates that ~~***fraud***~~**Fraud** may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a ~~*fraud*~~**Fraud** alert is received, CalOptima shall review its ~~*delegation*~~**Delegation** agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the ~~*delegation*~~**Delegation** agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a ~~*fraud*~~**Fraud** alert. With the issuance of a ~~*fraud*~~**Fraud** alert, **CMS** places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party ~~needs~~need to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged ~~*fraud*~~**Fraud** scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes ~~member~~**Member** complaints, **DHCS** Audits and Investigations referrals, MEDIC investigations, **OIG** and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of **Federal and/or State** ~~*health care programs*~~**Health Care Programs** requirements. CalOptima shall also maintain files that contain documented warnings (e.g., ~~*fraud*~~**Fraud** alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, **DHCS**, **CMS**, and **CMS'** ~~*designee*~~**Designee**, regarding ~~monitoring~~**Monitoring** of **FDRs** within CalOptima's network that **DHCS**, or **CMS**, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent **FWA** within a **CalOptima** ~~program~~**Program**. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of **FWA** activity. CalOptima shall assess all **FDRs** for potential ~~*overpayments*~~**Overpayments** when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return ~~*overpayments*~~**Overpayments** consistent with applicable laws and regulatory guidance. ~~Should revisions to reported data be~~

As required, CalOptima and/or the **FDR** shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of ~~*overpayment*~~**Overpayment** determinations to ~~regulatory agencies~~**Regulatory Agencies**, as required by law.

When applicable, CalOptima shall return **Overpayments** made to CalOptima, consistent with applicable state and federal laws and regulatory guidance.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of **FWA** are components of CalOptima's **Compliance Program**. **FWA** activities are implemented and overseen by CalOptima's **Compliance Officer,** or his/her ~~***designee***~~**Designee,** in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for **FWA** investigations. The **Compliance Officer,** or his/her ~~***designee***~~**Designee**, reports **FWA** activities to the CalOptima **Compliance Committee**, CEO, the **CalOptima Board**, and ~~regulatory agencies~~**Regulatory Agencies**.

CalOptima utilizes various resources to detect, prevent, and remediate **FWA**. In addition, CalOptima promptly investigates suspected **FWA** issues and ~~implements~~may implement disciplinary, or corrective, action to avoid recurrence of **FWA** issues. ~~–~~The objective of the **FWA** program is to ensure that the scope of benefits covered by the **CalOptima** ~~***programs***~~**Programs** is appropriately delivered to ~~***members***~~**Members** and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify **FWA** and promptly respond appropriately to such incidents of **FWA**.

I.FWA TRAINING

As detailed above, **FWA** training is provided to all **Board** ~~*members*~~**Members** and ~~*employees*~~**Employees** as part of the overall compliance training courses in order to help detect, prevent, and remediate **FWA**. **FDRs** are also required to complete **FWA** training, as described above. CalOptima's **FWA** training provides guidance to **Board** ~~*members, employees*~~**Members, Employees**, and **FDRs** on how to identify activities and behaviors that would constitute **FWA** and how to report suspected, or actual, **FWA** activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual **FWA**;
- Examples of the most common types of member **FWA** (see Appendix B, attached hereto and incorporated herein) and **FDR FWA** (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify **FWA** in **CalOptima** ~~*programs*~~**Programs** (e.g., suspicious activities suggesting CalOptima ~~members~~**Members**, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the **CalOptima** ~~*programs*~~**Programs**, etc.);
- Information on how to identify potential prescription drug **FWA** (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average ~~member~~**Member** in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential **FWA** using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for **FDRs**, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the **False Claims Act** and CalOptima's requirement to train ~~*employees*~~**Employees** and **FDRs** on the **False Claims Act** and other applicable **FWA** laws.

CalOptima shall provide **Board** ~~*members, employees*~~**Members, Employees**, **FDRs**, and ~~*members*~~**Members** with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with ~~the Regulatory Affairs & Compliance Department~~CalOptima internal departments, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of **FWA**. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. **Members**, **FDRs**, ~~*employees*~~**Employees**, law enforcement and ~~regulatory agencies~~**Regulatory Agencies,** and others ~~are able to~~may contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect **FWA** include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record ~~*audits*~~**Audits**;
- **Member** and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- **Auditing** and ~~*monitoring activities*~~**Monitoring Activities**;
- Monitoring external health care **FWA** cases and determining if CalOptima's **FWA** Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and ~~*audits*~~**Audits**.

b. Data Analytics

CalOptima uses technology and data analysis to reduce **FWA** externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect **FDRs** based on billing patterns.

CalOptima also uses the services of an external **Medicare Secondary Payer (MSP)** ~~vendor~~**Vendor** to reduce costs associated with its Medicare-Medicaid programs, such as the **OneCare**, **OneCare Connect**, and/or **PACE** programs, by ensuring that ~~Federal~~federal and ~~State~~state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data ~~is~~are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or ~~audited~~**Audited**. Any medical claim can be pended and reviewed in accordance with applicable state or federal law if they meet certain ~~criterion~~criteria that ~~warrants~~warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with

applicable state or federal law based on criteria focused on the types of drugs (~~for example~~e.g., narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the **PBM** will conduct data mining activities in order to identify potential issues of **FWA**.

The following trends will be reviewed and flagged for potential **FWA**, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual ~~Coding~~coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by ~~***members***~~**Members** and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected **FWA**. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the **PBM** will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or ~~makes arrangements~~arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a ~~***member***~~**Member** is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.

- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides ~~a number of~~several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a ~~member~~**Member** the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of **FWA**. The presence of several indicators may suggest **FWA**, but further investigation is needed to determine if a suspicion of **FWA** ~~actually~~ exists. The following list below highlights common industry indicators and red flags that are used to determine whether ~~or not~~ to investigate an **FDR** or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the ~~*member*~~**Member**/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the **FWA** database and a report is generated and submitted to the **Compliance Officer**, **Compliance Committee**, and CEO.

III.FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected **FWA** or detects **FWA** through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (~~Access~~access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an **FDR** to obtain relevant information;
- SIU, or a ~~***designee***~~**Designee**, interviews the individual who reported the **FWA**, affected ~~***members***~~**Members** and/or **FDRs**, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of **FDR** enrollment applications, history, and ownership, as necessary;
- Review of ~~member~~**Member** enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation ~~shall~~may be ~~forwarded~~reported to the **Compliance Officer** and **Compliance Committee**. If a CalOptima internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the **Compliance Committee** for ~~discussion and approval~~further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of **FWA**, need for contract amendment, education and training requirement, recommendation of focused ~~***audits***~~**Audits**, additional investigation, continued ~~monitoring~~**Monitoring**, new policy implementation, and/or criminal or civil action. When the root cause of the potential **FWA** issue has been identified, the SIU will track and trend the **FWA** allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the **Compliance Committee** on a quarterly basis. Investigation findings can be used to determine whether ~~or not~~ disciplinary, or corrective, action is appropriate, whether there is a need for

a change in CalOptima's ~~*policies*~~**Policies** **and** ~~*procedures*~~**Procedures**, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima ~~*policies*~~**Policies** **and** ~~*procedures*~~**Procedures**, CalOptima shall take appropriate disciplinary, or corrective, action against **Board** ~~*members, employees*~~**Members, Employees**, and/or **FDRs** related to validated instances of **FWA**. CalOptima will also assess **FDRs** for potential ~~*overpayments*~~**Overpayments** when reviewing and undertaking corrective actions. Corrective actions will be monitored by the **Compliance Committee**, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial ~~*sanctions*~~**Sanctions**, regulatory reporting, **Corrective Action Plans**, or termination of the ~~*delegation*~~**Delegation** agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, ~~CalOptima~~CalOptima's Office of Compliance will initiate review and discussion at the first **Compliance Committee** following the date of identification of the suspected **FWA**, the date of report to **DHCS**, or the date of **FWA** substantiation by **DHCS** subsequent to the report. If vulnerability is identified through a single **FWA** incident, the ~~correction~~corrective action may be applied universally.

b. Referral ~~T~~to Enforcement Agencies

CalOptima's SIU shall coordinate timely referrals of potential **FWA** to appropriate ~~regulatory agencies~~**Regulatory Agencies**, or their designated program integrity contractors, including the **CMS** MEDIC, **DHCS** Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. **FDRs** shall report **FWA** to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected **FWA**, should be reported to **CMS** and/or **DHCS**, as soon as possible after discovery, but no later than ten (10) working days to **DHCS** after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a **OneCare**, **OneCare Connect**, or **PACE** case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of **FWA**;
- Patterns of **FWA** threatening the life, or well-being, of CalOptima ~~*members*~~**Members**; and/or
- Schemes with large financial risk to CalOptima, or its ~~*members*~~**Members**.

IV.ANNUAL FWA EVALUATION

CalOptima's **Compliance Committee** shall periodically review and evaluate the **FWA** activities and its effectiveness as part of the overall **Compliance Program** ~~*audit*~~**Audit** and ~~*monitoring activities*~~**Monitoring Activities**. Revisions should be made based on industry changes, trends in **FWA** activities (locally and nationally), the **OIG** Work Plan, the CalOptima **Compliance Plan**, and other input from applicable sources.

a. Retention of Records

CalOptima shall maintain reports and summaries of **FWA** activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of ~~member~~**Member** records containing **PHI** in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of **FWA** investigations in a secure and confidential manner, regardless of the outcome of an investigation.

b. Confidentiality

CalOptima and its **FDRs** shall maintain all information associated with suspected, or actual, **FWA** in confidential files, which may only be released in accordance with applicable laws and CalOptima ~~*policies*~~**Policies** **and** ~~*procedures*~~**Procedures**. All participants and attendees of CalOptima's Quality Improvement Committee, **Compliance Committee**, and respective subcommittees~~,~~ shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the **Compliance Program**, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the **Compliance Program** against the elements of an effective **Compliance Program** as recommended by **OIG** and required by **CMS** regulations. The following areas will be reviewed:

- **Policies and** ~~***procedures***~~**Procedures**;
- **Compliance Officer** and **Compliance Committee**;
- Training and education of **Board** ~~***members, employees***~~**Members, Employees**, and **FDRs**;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal ~~monitoring~~**Monitoring** and ~~auditing~~**Auditing**;
- **Delegation** oversight;
- **Exclusion** and ~~preclusion~~**Preclusion** screening process; and
- Prompt responses to detected offenses.

The **Compliance Program** will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with ~~***senior management***~~**Executive Staff and Management**, the **Compliance Committee**, and the **CalOptima Board**. Updates to the **Compliance Program** will be based on the results of the evaluation and will be referred to the **CalOptima Board** for review and approval.

I.PRIVILEGED FILES AND DOCUMENT RETENTION

I.Privileged FILING SYSTEMS

The ***Compliance Officer,*** or his/her ***designee,*** shall establish and maintain a filing system (or systems) for all compliance-related documents. The following files shall be established at CalOptima (as applicable):

a. Compliance Plan, Code of Conduct, and Policies and Procedures File

This file shall contain copies of the following (unless originals specified):

- ***Compliance Plan*** and any amendments;
- Any ***Compliance Program policies and procedures*** issued after the initiation of the ***Compliance Program***;
- Reports to, and Resolutions/Minutes of CalOptima's Board approving the Compliance Program, ***Compliance Plan***, ***Code of Conduct*** and/or appointment of the ***Compliance Officer***;

a. Files

- All non-privileged communications to the ***Compliance Officer*** (original);
- All ***Compliance Committee*** and ***CalOptima Board*** minutes in which compliance issues are discussed; and/or
- Any other written records of the ***AOC***, or other oversight activities (originals if generated by the ***Compliance Officer***).

b. Information and Education File

files

This file shall contain copies of the following (unless originals specified):

- ***FDR*** training and attestation records (including attendance records, Affirmation Statements, and the outline of topics covered);
- ***Board member*** and ***employee*** training records, attestations, and attendance records are maintained by the Human Resources Department.
- Educational materials provided to ***Board members***, ***employees***, and ***FDRs***;
- Notices, ***fraud*** alerts, and/or federal and state laws and regulations which have been posted on bulletin boards, placed in payroll stuffers, or sent via print or electronic communication (and the dates and locations of such notices); and/or
- All other written records of training activities.

c. Monitoring, Enforcement, and Response File

This file shall contain copies of the following (unless originals specified):

- Records relating to compliance reports including reports to the Compliance and Ethics Hotline and/or to the ***Compliance Officer*** (originals);
- Records relating to periodic monitoring and auditing of the ***Compliance Program*** (originals);

- ~~Records relating to ***Board member***, ***employee***, and ***FDR Participation Status*** Review or background checks (originals except where ***FDRs*** perform ***Participation Status*** Reviews);~~
- ~~Records relating to established periodic monitoring mechanisms;~~
- ~~All documents pertaining to the enforcement of the ***Compliance Program***, including, investigations and disciplinary and/or corrective actions; and/or~~
- ~~All documents reflecting actions taken after an offense has been detected, and all efforts to deter and prevent future violations.~~

~~**d. Privileged File**~~

~~This file~~ shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. ~~-~~Only the **Compliance Officer**, CalOptima legal counsel, and the **Compliance Committee**, where appropriate, shall have access to its contents. ~~-~~All ~~material~~materials in ~~this~~the privileged file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. ~~-This~~The privileged file ~~contains~~shall contain the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the **Compliance Officer**;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning **FDR delegation** agreement interpretations and remedies available to CalOptima.

~~e.~~b. Document Retention

~~All of the documents to be maintained in the filing system described above shall be retained~~CalOptima shall retain contracts, books, documents, records, financial statements, and other data, as defined in Title 42, Code of Federal Regulations, Sections 438.5(c), 438.604, 606, 608, and 610, for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). ~~-~~Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract~~.~~ (except for privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

CalOptima shall maintain the documentation required by **HIPAA** for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) ~~***policies***~~**Policies and** ~~***procedures***~~**Procedures** (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by **HIPAA**; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under **HIPAA**; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A



Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste, and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste, and abuse. CalOptima is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of potential fraud, waste, and abuse and discuss employee and contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

Principle	Standard
	Political Activities CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment

Principle	Standard
	and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its physician groups, its health networks and third-party administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima policies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.

Principle	Standard
Public Integrity CalOptima and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima policies. **Public Funds** CalOptima, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and employees shall comply with applicable law and CalOptima policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures.

Principle	Standard
	Personnel Files Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima.

Principle	Standard
	Third-Party Sponsored Events CalOptima's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima policies on this subject. In no event, shall CalOptima participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at contractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.

Principle	Standard
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, and gender expression), sexual orientation, health status, physical or mental disability, or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, physician groups, and health networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of employees, individuals and entities doing business with CalOptima by conducting regular exclusion and preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its health networks, physician groups, and third--party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Principle	Standard
	Licensure CalOptima requires that all employees, contractors, health networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own policies in accordance with CalOptima's reporting policies and its Compliance Plan. Such reports may be made to a supervisor or the Compliance Officer. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's

Principle	Standard
	discretion, range from oral correction to termination in accordance with CalOptima's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or exclusion or preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, employees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable policies.

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Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a covered service for purposes other than the purpose for which it was described including use of such covered service.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.	Hotline reports; internal reports; reports by health networks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for covered services that are substantially and demonstrably in excess of any individual's usual charges for such covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for covered services that are in excess of the quantity that is medically necessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for covered services that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for covered services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for covered services that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for covered services.	Member report; hotline report; oversight audits.
P09	Billing a member for covered services without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits.
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.
P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight audit; report by regulatory body; hotline.

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P13	False certification of medical necessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate minimum standards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; hotline report; oversight audits.
P20	Durable Medical Equipment- covered services that are not actually provided to member.	Member report; hotline report; oversight audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a member's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

Appendix E

AFFIRMATION STATEMENTS

CalOptima
AFFIRMATION STATEMENT-SUPERVISORS

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

I understand that it is my responsibility to respond to questions from employees under my direct supervision regarding the Compliance Plan, Code of Conduct, or applicable Policies and Procedures. If I am unable to respond to questions from employees under my direct supervision, I will refer them to the Compliance Officer. In addition, I understand that if an employee under my direct supervision reports a violation or suspected violation of CalOptima's Compliance Program to me, I will escalate and report the issue to the Compliance Officer.

By signature below, I also certify that I have completed the Compliance Training as indicated:

I attended the initial Compliance Training Session on _____.

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

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CalOptima

AFFIRMATION STATEMENT-EMPLOYEES

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures specific to my job duties and responsibilities as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the Compliance Training Session on _____:

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-FDRs

I have received and read a copy of the Compliance Plan, Code of Conduct, and applicable Policies and Procedures relevant to the delegated activities, and I understand, acknowledge, and agree to abide by its contents and requirements.

I will disseminate the Compliance Plan, Code of Conduct, and applicable Policies and Procedures to those employees and agents who will furnish items or services to CalOptima under the Contractor Agreement.

_____
Print Name

_____
Signature

_____
Title

_____
Company

_____
Date

SIGN, DATE AND RETURN TO CalOptima SUPERVISOR

CalOptima

AFFIRMATION STATEMENT-BOARD MEMBERS

I have received and read a copy of the Compliance Plan, the Code of Conduct, and applicable Policies and Procedures, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the initial or regular training as indicated:

I attended the initial Compliance Training Session on _____.

I attended the annual Compliance Training Session on _____.

_____

Print Name

_____

Signature

_____

Date

RETURN TO THE COMPLIANCE OFFICER

E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit" or "Auditing") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one (1) of several acknowledged certifications.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director of Audit & Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima ~~members~~Members" or "~~members~~Members") means a beneficiary who is enrolled in a CalOptima program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima under contract with DHCS and CMS, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of ~~senior management staff~~**Executive Staff** that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, employees and FDRs comply with applicable law and ethical standards.

Compliance Risk Assessment ("CRA") A tool utilized to stratify level of risk (high, medium, low) based upon audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance

organizations licensed under the Knox-Keene Act, Health & Safety Code Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or **Employees** ("Employee" or "Employees") means any and all employees of CalOptima, including all ~~senior management~~Executive Staff, Management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

Exclusion ("Exclusion" or "Excluded") means suspension, exclusion, or debarment from participation in Federal and/or state health care programs.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

Executive Staff ("Executive Staff") means an employee whose position title is Chief, or Executive Director of one (1) or more departments.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State ~~health care programs~~Health Care Programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement,

acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a member under a CalOptima program.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

General Services Administration ("GSA") **System for Award Management** ("SAM") is a type of federal government exclusion database and contains the list of Excluded Parties List System (GSA-EPLS). The EPLS consists of federal contractors who have been debarred, sanctioned, or excluded due to government contract issues or fraud. The database is updated usually on a monthly basis.

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network ~~or Health Networks~~ ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Immediate Corrective Action Plan ("ICAP") means the result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Management ("Management") means any employee whose position title is Director, Senior Manager, Manager, or Supervisor of one (1) or more departments.

Medi-Cal Suspended & Ineligible ("S&I") **Provider List** is a list of suspended and ineligible providers that is maintained by DHCS in the Medi-Cal Provider Manual. The list is updated monthly and available online and in print from DHCS.

Medicare Secondary Payer (MSP) Vendor means third-party vendors contracted to perform administrative functions with regards to the identification and recovery of monies owed to OneCare or OneCare Connect for recoupment of conditional payments. These administrative duties include, but are not limited to, the pursuit of repayments for third party liabilities and other health care coverage.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Multipurpose Senior Services Program ("MSSP") is a program approved under the federal

Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of Inspector General List of Excluded Individuals and Entities ("OIG LEIE") is an exclusion list and contains individuals and/or entities that have been excluded from participation in federal healthcare programs such as Medicare and Medicaid. This list is usually updated on a monthly basis.

OneCare ("OneCare") is a Medicare Advantage Health Maintenance Organization (HMO) plan offered by CalOptima to provide Medicare covered benefits to Members.

OneCare Connect ("OneCare Connect") is a Medicare-Medicaid health plan offered by CalOptima that contracts with both Medicare and Medi-Cal to provide covered benefits of both programs to Members.

Overpayment ("Overpayment") means a payment disbursed in excess of amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating ~~providers~~**Providers and** ~~suppliers ("participating providers~~**Suppliers** ("Participating Providers and ~~suppliers~~Suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its health networks for items or services furnished to members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima policies and procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board ~~members~~Members, employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs.

Personally Identifiable Information ("PII") means any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Pharmacy Benefit Manager ("PBM") means an entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing

formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written policies and procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Program of All-Inclusive Care for the Elderly ("PACE") is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

Preclusion ("Precluded" or "Preclusion List") is a type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Protected Health Information ("PHI") refers to the 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

Regulatory Agencies ("Regulatory Agencies") include, but are not limited to: Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG), and the Office of Civil Rights (OCR).

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.

~~Senior Management ("Senior Management") means any employee whose position title is Chief Officer, Executive Director, or Director of one (1) or more departments.~~

Seniors and Persons with Disabilities ("SPD") means Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

Sub-delegation ("Sub-delegation") means the process by which a first tier entity expressly grants, by formal agreement, to a downstream entity the authority to carry out one or more functions that would otherwise be required to be performed by the first tier entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an employee in a position representing CalOptima who has one (1) or more employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima employee that is the designated liaison for that contractor.

Third–Party Administrator ("TPA") means a contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Orange County Health Authority
dba CalOptima

2020 Compliance Plan

(Revised December 2019)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, **Program of All-Inclusive Care for the Elderly (PACE)**, **Multipurpose Senior Services Program (MSSP)**, and other **CalOptima Programs**.*

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's **First Tier**, **Downstream**, and **Related Entities** (**FDRs**), such as **Health Networks**, physician groups, **Participating Providers, and Suppliers**, **Pharmacy Benefit Manager (PBM)**, and consultants. The term **FDR** is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the **Centers for Medicare & Medicaid Services** (**CMS**) and the **Department of Health Care Services** (**DHCS**). Such persons/entities, referred to as **FDR** herein, include those that directly contract with CalOptima and those that are **Downstream** or **Related Entities** (i.e., subcontracts) with CalOptima's **First Tier Entities**.

CalOptima has developed a comprehensive **Compliance Program** applicable to all of CalOptima's programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "**OneCare**"), its Medicare-Medicaid Plan (MMP referred to as "**OneCare Connect**"), **PACE**, and **MSSP**. The **Compliance Program** incorporates all elements of an effective **Compliance Program** as recommended by the **Office of the Inspector General** (**OIG**) and required by **CMS** regulations. The **Compliance Program** is continually evolving and may be modified and enhanced based on compliance **Monitoring** and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that **CalOptima Board Members**, **Employees**, and **FDRs** conduct themselves in accordance with the requirements of CalOptima's **Compliance Program**.

B. THE COMPLIANCE PLAN

This **Compliance Plan** sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The **Compliance Plan** addresses the fundamental elements of an effective **Compliance Program** and identifies how CalOptima is implementing each of the fundamental elements of an effective **Compliance Program** in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the **Compliance Plan** is designed to provide guidance and to ensure that CalOptima's operations and the practices of its **Board Members**, **Employees**, and **FDRs** comply with contractual requirements, ethical standards, and applicable law.

This **Compliance Plan** is adopted by the **Governing Body**. It was developed and is managed by the **Executive Director of Compliance** (hereinafter referred to as the "**Compliance Officer**") with the **Compliance Committee**. Due to the dynamic nature of the complex laws governing CalOptima and its programs, the **Compliance Plan** may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board Members, **Employees**, and **FDRs** are expected to review and adhere to the requirements and standards set forth in the **Compliance Plan**, the **Code of Conduct**, and all related **Policies and Procedures**, as may be amended. Furthermore, **Board Members**, **Employees**, and **FDRs** are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a **Board Member**, **Employee**, and/or **FDR** has/have any questions about the application, or implementation, of this **Compliance Plan**, or questions related to the **Code of Conduct** or CalOptima **Policies and Procedures**, he or she should seek guidance from the **Compliance Officer** and/or the CalOptima Office of Compliance.

I.WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of **Board Members**, **Employees**, and **FDRs**, CalOptima develops, maintains, and distributes its written standards in the form of this **Compliance Plan**, a separate **Code of Conduct**, and written **Policies and Procedures**.

a. Compliance Plan

As noted above, this **Compliance Plan** outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to **CalOptima Board Members**, **Employees**, and **FDRs**. This **Compliance Plan** also includes a comprehensive section articulating CalOptima's commitment to preventing **Fraud**, **Waste**, & **Abuse** (**FWA**), and setting forth guidelines and procedures designed to detect, prevent, and remediate **FWA** in the administration of **CalOptima Programs**. The **Compliance Plan** is available on CalOptima's external website for **Board Members** and **FDRs,** as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all **Employees**.

b. Policies and Procedures

CalOptima also developed written **Policies and Procedures** to address specific areas of CalOptima's operations, compliance activities, and **FWA** prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These **Policies and Procedures** are designed to provide guidance to **Board Members**, **Employees**, and **FDRs** concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. **Board Members**, **Employees**, and **FDRs** are expected to be familiar with the **Policies and Procedures** pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The **Compliance Officer**, or his/her **Designee**, will ensure that **Board Members**, **Employees**, and **FDRs** are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

The **Policies and Procedures** are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's **Policies and Procedures** are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to CalOptima's **Policies and Procedures**. **Policies and Procedures** are available on CalOptima's internal website and Compliance 360 (C360), a separate web portal accessible to **Board Members**, **Employees**, and **FDRs**. **Board Members**, **Employees**, and **FDRs** receive notice when **Policies and Procedures** are updated via a monthly memorandum.

c. Code of Conduct

Finally, the **Code of Conduct** is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the **Code of Conduct** is to articulate compliance expectations and broad principles that guide **CalOptima Board Members**, **Employees**, and **FDRs** in conducting their business activities in a professional, ethical, and lawful manner. The **Code of Conduct** is a separate document from the **Compliance Plan** and can be found in Appendix A. The **Code of Conduct** is approved by the **CalOptima Board of Directors** and distributed to **Board Members**, **Employees**, and **FDRs** upon appointment, hire, or the commencement of the contract, and annually thereafter. New **Board Members**, **Employees**, and **FDRs** are required to sign an attestation acknowledging receipt and review of the **Code of Conduct** within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the **Compliance Program** requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by the **CalOptima Board**, the **Compliance Officer**, the **Compliance Committee**, the **Audit & Oversight Committee**, and **Executive Staff**.

a. Governing Body

The **CalOptima Board of Directors**, as the **Governing Body**, is responsible for approving, implementing, and **Monitoring** a **Compliance Program** governing CalOptima's operations. The **CalOptima Board** delegates the **Compliance Program** oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the **Compliance Officer**. The **Compliance Officer** is an **Employee** of CalOptima, who handles compliance oversight and activities full-time. The **Compliance Officer**, in conjunction with the **Compliance Committee**, are both accountable for the oversight and reporting roles and responsibilities as set forth in this **Compliance Plan**. However, the **CalOptima Board** remains accountable for ensuring the effectiveness of the **Compliance Program** within CalOptima and **Monitoring** the status of the **Compliance Program** to ensure its efficient and successful implementation.

To ensure the **CalOptima Board** exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's **Compliance Program**, the **CalOptima Board**:

- Understands the content and operation of CalOptima's **Compliance Program**;
- Approves the **Compliance Program**, including this **Compliance Plan** and the **Code of Conduct**;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the **Compliance Program** outcomes, including, but not limited to, results of internal and external **Audits**;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the **Compliance Program**;
- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, **Corrective Action Plans**, Warning Letters, and/or **Sanctions**;
- Receives regularly scheduled, periodic updates from CalOptima's **Compliance Officer** and **Compliance Committee**, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the **Compliance Program**.

The **CalOptima Board** reviews the measurable indicators of an effective **Compliance Program** and remains appropriately engaged in overseeing its efficient and successful implementation; however, the **CalOptima Board** delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The **Executive Director of Compliance** serves as the **Compliance Officer** who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the **Compliance Program**. The **Compliance Officer** reports directly to the CEO and the **Compliance Committee** on the activities and status of the **Compliance Program**. The **Compliance Officer** has authority to report matters directly to the **CalOptima Board** at any time. Furthermore, the **Compliance Officer** ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The **Compliance Officer** interacts with the **CalOptima Board**, CEO, CalOptima's Executive Staff and departmental Management, **FDRs**, legal counsel, state and federal representatives, and others as required. In addition, the **Compliance Officer** supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, **FDR** and internal oversight, **Policies and Procedures**, and training on compliance activities.

The **CalOptima Board** delegates the following responsibilities to the **Compliance Officer**, and/or his/her **Designee(s)**:

- Chair the **Compliance Committee**, which shall meet no less than quarterly and assists the **Compliance Officer** in fulfilling his/her responsibilities;
- Ensure that the **Compliance Program**, including this **Compliance Plan** and **Policies and Procedures**, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected **Board Members**, **Employees**, and **FDRs**, as appropriate;
- Oversee and monitor the implementation of the **Compliance Program**, and provide regular reports no less than quarterly to the **CalOptima Board** and CEO summarizing all efforts, including, but not limited to, the **Compliance Committee**'s efforts to ensure adherence to the **Compliance Program**, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and **Audit** activities;
- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential **FWA** received from any source through any reporting method;
- Design, coordinate, and/or conduct regular internal **Audits** to ensure the **Compliance Program** is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of **Compliance Program** activities for each of CalOptima's programs, and regularly report CalOptima's progress in implementing those plans to the appropriate **Board** committee and/or to the **Board of Directors**;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or **FWA** issues, including facilitating any documentation or procedural requests by such agency(s);
- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., **DHCS** and **CMS**) and consult with legal counsel, as necessary;
- Create and coordinate educational training programs and initiatives to ensure that the **CalOptima Board**, **Employees**, and **FDRs** are knowledgeable about CalOptima's

Compliance Program, including the **Code of Conduct**, **Policies and Procedures**, and all current and emerging applicable statutory and regulatory requirements;

- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate **Corrective Action Plans**, **Sanctions**, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and **FDRs** to ensure **Exclusion** and **Preclusion** screening (including through the **OIG List of Excluded Individuals and Entities (LEIE)**, **General Services Administration (GSA) System for Award Management (SAM)**, **Medi-Cal Suspended & Ineligible (S&I) Provider List**, and the **CMS Preclusion List**) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The **Compliance Committee**, chaired by the **Compliance Officer**, is composed of CalOptima's **Executive Staff** and operational staff, as designated by the CEO. The members of the **Compliance Committee** serve at the discretion of the CEO and may be removed, or added, at any time. The role of the **Compliance Committee** is to implement and oversee the **Compliance Program** and to participate in carrying out the provisions of this **Compliance Plan**. The **Compliance Committee** meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the **Compliance Program**.

The **CalOptima Board** delegates the following responsibilities to the **Compliance Committee**:

- Maintain and update the **Code of Conduct** consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the **CalOptima Board**;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of **Compliance Committee** meetings reflecting reports made to the **Compliance Committee** and the **Compliance Committee's** decisions on the issues raised (subject to all applicable privileges);
- Review and **Monitor** the effectiveness of the **Compliance Program**, including **Monitoring** key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the **Compliance Officer** to ensure the adequacy of the **Compliance Program**;
- Review, approve, and/or update **Policies and Procedures** to ensure the successful implementation and effectiveness of the **Compliance Program** consistent with regulatory, legal, and contractual requirements;
- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and **Policies and Procedures** as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the **Compliance Officer** accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of **Monitoring** and **Auditing** of areas in which CalOptima is at risk of program non-compliance and/or potential **FWA**, and ensure **CAPs** and **ICAPs** are implemented and **Monitored** for effectiveness;

- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its **FDRs** conduct activities and operations in compliance with the applicable laws and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the **CalOptima Board of Directors**.

d. Audit & Oversight Committee (AOC)

The **Audit & Oversight Committee** (**AOC**) is a subcommittee of the **Compliance Committee** and is co-led by the Director(s) of Audit & Oversight. The **AOC** is responsible for overseeing the delegated and internal activities of CalOptima. The **Compliance Committee** has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee. In addition to the monthly scheduled meetings, the **AOC** may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the **AOC** are approved by the majority of a quorum of the **AOC**. A quorum is defined as one (1) over fifty percent (50%). **AOC** may approve and/or implement **Corrective Action Plans** (**CAPs**); however, recommendations for **FDR Sanctions** and/or de-**Delegation** are submitted to the **Compliance Committee** for final approval. The **AOC** also contributes to external reviews and accreditation **Audits**, such as the **National Committee for Quality Assurance** (**NCQA**).

Responsibilities of the **Audit & Oversight Committee** with regard to **FDRs** include:

- Annual review, revision, and approval of the **Audit** tools;
- Review findings of the readiness assessment to evaluate a potential **FDR**'s ability to perform the delegated function(s);
- Review and approve potential **FDR** entities for **Delegation** of functions;
- Ensure written agreements with each delegated **FDR** clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and **Monitoring** of **FDR** performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite **Audit**;
- Ensure all **Downstream** and **Related Entities** are **Monitored** in accordance with CalOptima oversight procedures;
- Ensure that formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage **Corrective Action Plans** (**CAPs**) for compliance issues;
- Propose **Sanctions**, subject to the **Compliance Committee's** approval, if an **FDR's** performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of **Delegation**, to the **Compliance Committee** for unresolved issues of compliance.

Responsibilities of the **Audit & Oversight Committee** regarding internal business functions include:

- Annual review, revision, and approval of the **Audit** work plan and **Audit** tools;
- Conduct formal, ongoing evaluation and **Monitoring** of internal business areas' performance and compliance through review of periodic reports submitted, ongoing **Monitoring**, and findings of the annual **Audit**;

- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage **Corrective Action Plans** (**CAPs**) for compliance issues.
- Initiate and manage other disciplinary actions (e.g., sanctions, de-delegation) for compliance issues.

e. Executive Staff

The CEO and **Executive Staff** of CalOptima shall:

- Ensure that the **Compliance Officer** is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective **Compliance Program**;
- Receive periodic reports from the **Compliance Officer** of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including **Audit** findings, Notices of Non-Compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III.TRAINING

Education and training are critical elements of the **Compliance Program**. CalOptima requires that all **Board Members**, **Employees**, and **FDRs** complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's **Code of Conduct**, compliance obligations, relevant laws, and **FWA**, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing **Seniors and People with Disabilities (SPD)** and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the **Compliance Program**, and which courses are updated regularly to ensure that **Employees** are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The **Compliance Officer,** or his/her **Designee,** is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/**FDR's** completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The **Compliance Officer** and the CalOptima **Executive Staff** and **Management** are responsible for ensuring that **Board Members**, **Employees**, and **FDRs** complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's **Code of Conduct** to **Board Members**, **Employees**, and **FDRs**. **Board Members**, **Employees**, and **FDRs** are required to sign an attestation acknowledging receipt, review, and understanding of the **Code of Conduct** within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the **Code of Conduct** is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each individual's personnel file, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires **Board Members**, **Employees**, and **FDRs**, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the **Compliance Program**; **FWA** training; **Health Insurance Portability and Accountability Act of 1996** (**HIPAA**) privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the **Compliance Program** are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or **FWA** issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's **HIPAA** privacy and security training course covers the administrative, technical, and physical safeguards necessary to secure **Members' Protected Health Information**

(PHI) and **Personally Identifiable Information (PII)**.

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the **Compliance Program** requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each **Employee**. **Board Members** and **FDRs** are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some **FDRs** may be exempt or deemed to have met the **FWA** training and education requirement if the **FDR** has met the **CMS** requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the **Compliance Program**. These training opportunities are available to **Managers** and **Employees** depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing **Managers** the tools and resources to train and share the information with **Employees** in their respective departments. If additional training related to **FWA** is required, the **Compliance Officer,** or his/her **Designee,** will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's **Policies and Procedures** governing the **Compliance Program** and pertinent to their respective roles and responsibilities. **Employees** may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board Members receive a copy of the **Compliance Plan**, **Code of Conduct**, and **Policies and Procedures** pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the **CalOptima Board**. **Board Members** may receive additional compliance training related to the **CalOptima Board**'s role in overseeing and ensuring organizational compliance with CalOptima's **Compliance Program**.

The **Code of Conduct** and **Policies and Procedures** pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to **FDRs** upon commencement of the **FDR** contract. **FDRs** are required to disseminate copies of the **Code of Conduct** and **Policies and Procedures** to their **Employees**, agents, and/or **Downstream Entities**. CalOptima may also develop compliance training and education presentations and/or roundtables for specified **FDRs**.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the **Compliance Program** and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to **Policies and Procedures**, contact information for the **Compliance Officer**, relevant federal and state **Fraud** alerts and policy letters, pending/new legislation reports, and advisory bulletins from the **Compliance Officer** to **CalOptima Board Members**, **Employees**, **FDRs**, and **Members**, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the **CalOptima Board**, **FDRs**, **Employees**, and individual CalOptima departments, and **Members**.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to **Board Members**, **Employees**, and **FDRs**, which contains CalOptima's updated **Policies and Procedures**.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to **Board Members**, **Employees**, **FDRs**, and **Members**.
- Electronic Mail – The CEO, **Compliance Officer**, or their respective **Designee**, periodically sends out email communications and/or alerts to **Board Members**, **Employees**, and **FDRs**, and/or **Members**, as applicable.
- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to **Employees**.
- CalOptima's Compliance Internal Website – The Office of Compliance maintains an internal department website accessible to CalOptima **Employees** to communicate different Compliance initiatives, notices, key documents and forms, and updates to the **Compliance Program**, **Code of Conduct**, and/or **Policies and Procedures**.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and **FWA** throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima **Employees**.
- Written Reports – The **Compliance Officer**, in coordination with the CEO and **Compliance Committee**, prepares written reports, no less than quarterly, concerning the status of the **Compliance Program** to be presented to the **CalOptima Board**.
- Direct Contact with the **Compliance Officer** - **Board Members**, **Employees**, and **FDRs** can obtain additional compliance information directly from the **Compliance Officer**. Any questions, which cannot be answered by the **Compliance Officer**, shall be referred to the **Compliance Committee**.

b. Reporting Mechanisms

CalOptima Board Members, **Employees**, and **FDRs** have an affirmative duty and are directed in CalOptima's **Code of Conduct** and **Policies and Procedures** to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by **Board Members**, **Employees**, and/or **FDRs** to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination

of employment, or termination of an **FDR** contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or **FWA** incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and **FWA** issues are also provided to **Board Members**, **Employees**, **FDRs**, and **Members** in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or **FWA**.

Upon receipt of a report through one (1) of the listed mechanisms, the **Compliance Officer**, or his/her **Designee**, shall follow appropriate **Policies and Procedures** to promptly review, investigate, and resolve such matters. The **Compliance Officer,** or his/her **Designee**, shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to Management or Executive Staff*

CalOptima **Employees** are encouraged to contact their immediate **Management** or **Executive Staff** when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. **Executive Staff** or **Management** will promptly escalate the report to the **Compliance Officer** for further investigation and reporting to the CalOptima **Compliance Committee**. If an **Employee** is concerned that his/her **Management** or **Executive Staff** did not adequately address his/her report or complaint, the **Employee** may go directly to the **Compliance Officer**, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with multilingual support, in which CalOptima may receive anonymous issues on a confidential basis. **Members** are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or **FWA** issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all **Board Members**, **Employees**, **FDRs**, and **Members**. **Members** also have access to the **Compliance Officer** through the Compliance and Ethics Hotline and/or the right to contact the **OIG** Compliance Hotline (1-800-447-8477) directly.

3. *Report Directly to the Compliance Officer*

The **Compliance Officer** is available to receive reports of suspected or actual compliance violations, or **FWA** issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from **Board Members**, **Employees**, **FDRs** and **Members**. The **Compliance Officer** may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. **FDRs** are generally contractually obligated to report suspected **Fraud** and **Abuse** to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or **FWA**, issues in good faith. This non-retaliation policy extends to reports received from **FDRs** and **Members**. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic **Member** notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the **Compliance Officer** will review and enforce disciplinary and/or other **Corrective Action Plans** for violations, as appropriate, with the approval of the **Compliance Committee**.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board Members, **Employees**, and **FDRs** are provided copies of CalOptima's **Code of Conduct** and the **Compliance Plan** and have access on CalOptima's internal and external website to applicable **Policies and Procedures**, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards and Office of Compliance Policies addressing **Corrective Action Plans** and **Sanctions**. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board Members, **Employees**, and **FDRs** are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the **Compliance Program** documents and related **Policies and Procedures**, including CalOptima Policy GA.8022: Performance and Behavior Standards, as applicable. **Board Members**, **Employees**, and **FDRs** may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's **Compliance Program** and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in **Federal and/or State Health Care Programs**;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, **Policies and Procedures** and/or contracts; or
- Failure to report violations or suspected violations of the **Compliance Program**, or applicable laws, or to report suspected or actual **FWA** issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates **HIPAA** and other privacy laws and/or CalOptima's **HIPAA** privacy and security policies, including actions that harm the privacy of **Members**, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the **Compliance Program** shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, **Sanctions**, and/or termination, depending on the nature and severity of the conduct, or behavior. **Board Members** may be subject to removal, **Employees** are subject to discipline, up to and including termination, and **FDRs** may be sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative **Sanctions** and/or penalties. Further violations could lead to suspension, **Preclusion**, or **Exclusion**, from participation in **Federal and/or State Health Care Programs**.

CalOptima **Employees** shall be evaluated annually based on their compliance with CalOptima's

Compliance Program. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

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VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with **Monitoring** and **Auditing** are identified through a combination of activities: risk assessments, **Audit & Oversight Committee** and **Compliance Committee** discussions and decisions, and internal and external reporting. Through **Monitoring**, **Auditing**, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The **Compliance Officer,** or his/her **Designee,** will collaborate with the **Compliance Committee** to identify areas of focus for **Monitoring** and **Auditing** potential non-compliant activity and **FWA** issues. A **Compliance Risk Assessment** will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of **FDRs**. Operations and processes will be evaluated based on: (1) deficiencies found by **Regulatory Agencies**; (2) deficiencies found by internal and external **Audit** and **Monitoring** reports; (3) the institution of new or updated **Policies and Procedures**; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by **CMS** and the **OIG** Work Plan shall be used as resources to evaluate operational risks.

The **Compliance Officer,** or his/her **Designee,** will work with the Chief Operating Officer, or his/her **Designee**, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and **Auditing**. Those operational areas determined to be high risk may be subject to more frequent **Monitoring** and **Auditing**, as well as additional reporting requirements. The risk assessment process will be managed by the **Compliance Officer**, or his/her **Designee**, and presented to the **AOC**, and subsequently to the **Compliance Committee**, for review and approval. **Monitoring** plans will be developed in collaboration with the operational areas, and focused **Audits** may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine **Auditing** and **Monitoring Activities** to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima **Policies and Procedures** to protect against non-compliance and potential **FWA** in **CalOptima Programs**. CalOptima and **FDRs** shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. **Monitoring Activities** are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An **Audit** is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a set of standards (e.g., **Policies and Procedures**, laws, and regulations) used as base measures. As part of the **Monitoring** process, CalOptima has created a dashboard, which is a **Monitoring** tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with **Monitoring** operations and outcomes

and to identify areas in need of targeted **Auditing** on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop **Monitoring** and **Auditing** work plans. **Monitoring** and **Auditing** work plans are used to detect potential areas of risk and/or non-compliant activity. The **Monitoring** and **Auditing** work plans are subject to daily updates and additions, and are therefore, working documents. The **Compliance Officer**, or his/her **Designee,** in collaboration with the **AOC** and **Compliance Committee**, develops the **Monitoring** and **Auditing** work plans to address the risks associated with each of **CalOptima's Programs**.

The **Compliance Officer,** or his/her **Designee,** will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate **Auditing** and **Monitoring Activities**. **Audits** for each operational area will be conducted throughout the year consistent with the **Monitoring** and **Auditing** work plans. The **Compliance Officer**, or his/her **Designee,** will coordinate the **Audits** with internal audit staff, and, in some cases, with the assistance from an outside vendor. **Audit** methodologies shall be consistent with regulatory and **NCQA** requirements and standards. All **Audits** will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the **Audit** review is completed, the Audit & Oversight teams will communicate the results to the **Compliance Officer** and propose follow up corrective action(s), if necessary. The **Compliance Officer,** or his/her **Designee,** will provide reports to the CEO and the **Compliance Committee** concerning the results of the **Audits**. The **AOC** reports to the **Compliance Officer** and the **Compliance Committee** on **Audits** that involve **FDRs** as discussed below. If **FWA** issues are identified during an **Audit**, the matter will be further investigated and resolved in a timely manner. In addition, an **Audit** of the **Compliance Program** and its effectiveness should occur at least annually, and the results shall be reported to the **CalOptima Board**.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to **CMS**, **DHCS**, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight **Monitoring** and **Auditing** process of **FDRs** who perform delegated activities. The processes that CalOptima implements to oversee, **Monitor**, and **Audit FDRs** are incorporated into CalOptima's written **Policies and Procedures**, including processes involving pre-contractual evaluations and **Audits** of **First Tier Entities**. CalOptima may implement **Corrective Action Plans**, **Sanctions**, and/or revoke its **Delegation** of duties (in a manner permitted under the contract) if CalOptima determines that an **FDR** is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The **Compliance Officer**, or his/her **Designee**, determines the process for **Monitoring** delegated **FDRs** and develops the annual **Monitoring** and **Audit** calendar in order to validate compliance with contractual standards and regulatory requirements. The **AOC** is responsible for overseeing all of the delegated activities and will review the readiness assessment, ensure the annual review of **FDRs** for delegated functions are completed, conduct formal on-going evaluation of **FDR** performance and compliance, ensure **Downstream** and **Related Entities** are monitored, and impose **Corrective Action Plans** and/or **Sanctions** if the **FDR**'s performance fails to meet statutory and contractual standards and requirements. The **AOC** may recommend termination of **Delegation** to the **Compliance Committee** for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or **Delegation** agreement with a potential **FDR**, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's **Policies and Procedures**, is completed to determine the ability of the potential **FDR** to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, **CMS**, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not **Precluded** on the **Preclusion List**, excluded in the **OIG List of Excluded Individuals/Entities (LEIE)**, the **General Services Administration (GSA) System of Award Management (SAM)**, or the **Medi-Cal Suspended & Ineligible (S&I) Provider List** from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the **AOC** and subsequently the **Compliance Committee** for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the **Delegation** agreement specifies the activities CalOptima delegates to the **FDRs**, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and **Audits**, and remedies, including disciplinary actions, available to CalOptima. Prior to any **Sub-delegation** to any **Downstream** or **Related Entity**, a **First Tier Entity** must obtain approval from CalOptima. CalOptima determines who will directly monitor the **Downstream** or **Related Entity's** compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the **FDR** and their contractually delegated area(s). Furthermore, **FDRs** will be required to complete, sign, and return attestation forms confirming the **FDR**'s compliance with new hire and annual training and education requirements, which includes courses on general compliance and **FWA** as well as **Exclusion** and **Preclusion** screening and **FWA** reporting obligations.

3. *Annual Risk Assessment*

The **Compliance Officer**, or his/her **Designee**, will ensure that an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate) to determine the **FDR's** vulnerabilities and high-risk areas. High-risk **FDRs** are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any **FDR** deemed high risk, or vulnerable, is presented to the **AOC** for suggested follow-up **Audit**. **FDRs** determined to be high risk may be subjected to a more frequent **Monitoring** and **Auditing** schedule, as well as additional reporting requirements. The risk assessment process, along with reports from **FDRs**, will be managed by the **Compliance Officer**, or his/her **Designee**, and presented to the **AOC**

and subsequently to the **Compliance Committee** for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the **FDR's** ability to provide delegated services in accordance with contractual standards and applicable state, **CMS**, and accreditation requirements, as further detailed in CalOptima's **Policies and Procedures**. CalOptima may conduct **Audits** of **FDRs** at any time. Such **Audits** may include an evaluation of the **FDR's** training and education program and materials covering general compliance and **FWA**, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk **FDRs**, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual **Audit** calendar; however, CalOptima does not limit its **Auditing** schedule to only high-risk **FDRs**.

If CalOptima has reason to believe the **FDR's** ability to perform a delegated function is compromised, an additional focused **Audit** may be performed. The **Compliance Officer,** or his/her **Designee**, may also recommend focused **Audits** upon evaluation of non-compliant trends or reported incidents. The results of these **Audits** will be reported to the **AOC** and then to the **Compliance Committee**.

A focused **Audit** may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or CalOptima's service level performance indicators;
- Failure to comply with a **Corrective Action Plan**;
- Reported or alleged **Fraud**, **Waste**, and/or **Abuse**;
- Significant policy variations that deviate from the CalOptima or state, **CMS**, or accreditation requirements;
- Bankruptcy, or impending bankruptcy, which may impact services to **Members** (either suspected or reported);
- Sale, merger, or acquisition involving the **FDR**;
- Significant changes in the management of the **FDR**; and/or
- Changes in resources which impact CalOptima's and/or the **FDR's** operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The **Compliance Officer,** or his/her **Designee**, shall submit regular reports of all monitoring, **Audit**, and corrective action activities to the **Compliance Committee**. In instances where non-compliance is identified, a **Corrective Action Plan** shall be developed by the **FDR** and reviewed and approved by the **Compliance Officer**, or his/her **Designee**. Every **Corrective Action Plan** is presented to the AOC, in aggregate, with no less than quarterly updates, and recommendations for escalation, as applicable. Supplemental and focused **Audits** of **FDRs**, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement **Sanctions** or require remediation by an **FDR** for failure to fulfill contractual obligations including development and implementation of a **Corrective Action Plan**. Failure to cooperate with CalOptima in any manner may result in termination of the **Delegation** agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's **Auditing** process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the **Auditing** processes, including **Policies and Procedures**, **Audit** tools, and **Audit** findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- The central database of all pending, active, and terminated **FDRs** to monitor and track functions, performance, and **Audit** schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of **Audit** tools;
- Implementation of a process for noticing **FDRs** and functional areas of **Corrective Action Plans**;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding **Delegation** standards, **Auditing**, and **Monitoring FDR** performance; and/or
- Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of **FDR** performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight **Audits** completed within twelve (12) months; and
- **Corrective Action Plans** (**CAPs**) completed within the established time frame.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's **Policies and Procedures**, CalOptima performs **Participation Status Reviews** by searching the **OIG –LEIE**, the **GSA–SAM**, the **DHCS Medi-Cal Suspended & Ineligible Provider Lists**, and the **CMS Preclusion List** upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure **Board Members**, **Employees**, and/or **FDRs** are not excluded, or do not become excluded or precluded from participating in **Federal and/or State Health Care Programs**. **Board Members**, **Employees**, and **FDRs** are required to disclose their **Participation Status** as part of their initial appointment, employment, commencement of the contract and registration/application processes and when **Board Members**, **Employees**, and **FDRs** receive notice of a suspension, **Preclusion**, **Exclusion**, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its **First Tier Entities** comply with **Participation Status Review** requirements with respect to their relationships with **Downstream Entities**, including without limitation, the delegated credentialing and re-credentialing processes.

The **Compliance Officer,** or his/her **Designee,** will review reports from **Employees** responsible for

conducting the **Participation Status Reviews** to ensure **Employees** record and maintain the results of the reviews and notices/disclosures. **Employees** shall immediately notify the **Compliance Officer**, or his/her **Designee,** of affirmative findings of a person, or entity's, failure to meet the **Participation Status Review** requirements. If CalOptima learns that any prospective, or current, **Board Member**, **Employee**, or **FDR** has been proposed for **Exclusion**, **Excluded**, or **Precluded**, CalOptima will promptly remove him/her/the **FDR** from **CalOptima's Programs** consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of their suspension, **Exclusion**, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the **CMS Preclusion List**, consistent with regulatory guidance, applicable policies, and/or contract terms. The **Compliance Officer,** or his/her **Designee**, will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII.RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's **Compliance Program** and/or **FWA** issues, the **Compliance Officer,** or his/her **Designee**, shall, upon promptly verifying the facts related to the violation or likely violation, notify the **Compliance Committee**, as appropriate. The **Compliance Committee** (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, **Sanctions**, termination of any agreement and/or any other corrective action consistent with applicable **Policies and Procedures**, subject to consultation with legal counsel and/or notifying the **Governing Body**, as appropriate;
- Implementing education and training programs for **Board Members**, **Employees**, and/or **FDRs**, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's **Compliance Plan**, **Code of Conduct**, and/or relevant **Policies and Procedures** to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the **Compliance Officer** and the **Compliance Committee** to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable **Policies and Procedures** after considering such recommendations. The **Compliance Officer**, or his/her **Designee**, may monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to **DHCS** Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning **Fraud** schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims activity indicates that **Fraud** may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a **Fraud** alert is received, CalOptima shall review its **Delegation** agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if

indictments have been issued against the particular parties and the terms of the **Delegation** agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a **Fraud** alert. With the issuance of a **Fraud** alert, **CMS** places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party need to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged **Fraud** scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes **Member** complaints, **DHCS** Audits and Investigations referrals, MEDIC investigations, **OIG** and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of **Federal and/or State Health Care Programs** requirements. CalOptima shall also maintain files that contain documented warnings (e.g., **Fraud** alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, **DHCS**, **CMS**, and **CMS' Designee**, regarding **Monitoring** of **FDRs** within CalOptima's network that **DHCS**, or **CMS**, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent **FWA** within a **CalOptima Program**. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of **FWA** activity. CalOptima shall assess all **FDRs** for potential **Overpayments** when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return **Overpayments** consistent with applicable laws and regulatory guidance.

As required, CalOptima and/or the **FDR** shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of **Overpayment** determinations to **Regulatory Agencies**, as required by law.

When applicable, CalOptima shall return **Overpayments** made to CalOptima, consistent with applicable state and federal laws and regulatory guidance.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of **FWA** are components of CalOptima's **Compliance Program**. **FWA** activities are implemented and overseen by CalOptima's **Compliance Officer,** or his/her **Designee,** in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for **FWA** investigations. The **Compliance Officer,** or his/her **Designee**, reports **FWA** activities to the CalOptima **Compliance Committee**, CEO, the **CalOptima Board**, and **Regulatory Agencies**.

CalOptima utilizes various resources to detect, prevent, and remediate **FWA**. In addition, CalOptima promptly investigates suspected **FWA** issues and may implement disciplinary, or corrective, action to avoid recurrence of **FWA** issues. The objective of the **FWA** program is to ensure that the scope of benefits covered by the **CalOptima Programs** is appropriately delivered to **Members** and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify **FWA** and promptly respond appropriately to such incidents of **FWA**.

I.FWA TRAINING

As detailed above, **FWA** training is provided to all **Board Members** and **Employees** as part of the overall compliance training courses in order to help detect, prevent, and remediate **FWA**. **FDRs** are also required to complete **FWA** training, as described above. CalOptima's **FWA** training provides guidance to **Board Members**, **Employees**, and **FDRs** on how to identify activities and behaviors that would constitute **FWA** and how to report suspected, or actual, **FWA** activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual **FWA**;
- Examples of the most common types of member **FWA** (see Appendix B, attached hereto and incorporated herein) and **FDR FWA** (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify **FWA** in **CalOptima Programs** (e.g., suspicious activities suggesting CalOptima **Members**, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the **CalOptima Programs**, etc.);
- Information on how to identify potential prescription drug **FWA** (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average **Member** in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential **FWA** using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for **FDRs**, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the **False Claims Act** and CalOptima's requirement to train **Employees** and **FDRs** on the **False Claims Act** and other applicable **FWA** laws.

CalOptima shall provide **Board Members**, **Employees**, **FDRs**, and **Members** with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with CalOptima internal departments, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of **FWA**. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. **Members**, **FDRs**, **Employees**, law enforcement and **Regulatory Agencies,** and others may contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect **FWA** include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record **Audits**;
- **Member** and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- **Auditing** and **Monitoring Activities**;
- Monitoring external health care **FWA** cases and determining if CalOptima's **FWA** Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and **Audits**.

b. Data Analytics

CalOptima uses technology and data analysis to reduce **FWA** externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect **FDRs** based on billing patterns.

CalOptima also uses the services of an external **Medicare Secondary Payer (MSP) Vendor** to reduce costs associated with its Medicare-Medicaid programs, such as the **OneCare**, **OneCare Connect**, and/or **PACE** programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or **Audited**. Any medical claim can be pended and reviewed in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and challenges previously

reported pertaining to certain pharmacies. CalOptima along with the **PBM** will conduct data mining activities in order to identify potential issues of **FWA**.

The following trends will be reviewed and flagged for potential **FWA**, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by **Members** and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected **FWA**. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the **PBM** will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a **Member** is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.

- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a **Member** the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of **FWA**. The presence of several indicators may suggest **FWA**, but further investigation is needed to determine if a suspicion of **FWA** exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an **FDR** or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the **Member**/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the **FWA** database and a report is generated and submitted to the **Compliance Officer**, **Compliance Committee**, and CEO.

III.FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected **FWA** or detects **FWA** through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an **FDR** to obtain relevant information;
- SIU, or a **Designee**, interviews the individual who reported the **FWA**, affected **Members** and/or **FDRs**, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of **FDR** enrollment applications, history, and ownership, as necessary;
- Review of **Member** enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the **Compliance Officer** and **Compliance Committee**. If a CalOptima internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the **Compliance Committee** for further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of **FWA**, need for contract amendment, education and training requirement, recommendation of focused **Audits**, additional investigation, continued **Monitoring**, new policy implementation, and/or criminal or civil action. When the root cause of the potential **FWA** issue has been identified, the SIU will track and trend the **FWA** allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the **Compliance Committee** on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's **Policies and Procedures**, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima **Policies and Procedures**, CalOptima shall take appropriate disciplinary, or corrective, action against **Board Members**, **Employees**, and/or **FDRs** related to validated instances of **FWA**. CalOptima will also assess **FDRs** for potential **Overpayments** when reviewing and undertaking corrective actions. Corrective actions will be monitored by the **Compliance Committee**, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial **Sanctions**, regulatory reporting, **Corrective Action Plans**, or termination of the **Delegation** agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima's Office of Compliance will initiate review and discussion at the first **Compliance Committee** following the date of identification of the suspected **FWA**, the date of report to **DHCS**, or the date of **FWA** substantiation by **DHCS** subsequent to the report. If vulnerability is identified through a single **FWA** incident, the corrective action may be applied universally.

b. Referral to Enforcement Agencies

CalOptima's SIU shall coordinate timely referrals of potential **FWA** to appropriate **Regulatory Agencies**, or their designated program integrity contractors, including the **CMS** MEDIC, **DHCS** Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. **FDRs** shall report **FWA** to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected **FWA**, should be reported to **CMS** and/or **DHCS**, as soon as possible after discovery, but no later than ten (10) working days to **DHCS** after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a **OneCare**, **OneCare Connect**, or **PACE** case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of **FWA**;
- Patterns of **FWA** threatening the life, or well-being, of CalOptima **Members**; and/or
- Schemes with large financial risk to CalOptima, or its **Members**.

IV.ANNUAL FWA EVALUATION

CalOptima's **Compliance Committee** shall periodically review and evaluate the **FWA** activities and its effectiveness as part of the overall **Compliance Program Audit** and **Monitoring Activities**. Revisions should be made based on industry changes, trends in **FWA** activities (locally and nationally), the **OIG** Work Plan, the CalOptima **Compliance Plan**, and other input from applicable sources.

a. Retention of Records

CalOptima shall maintain reports and summaries of **FWA** activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of **Member** records containing **PHI** in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of **FWA** investigations in a secure and confidential manner, regardless of the outcome of an investigation.

b. Confidentiality

CalOptima and its **FDRs** shall maintain all information associated with suspected, or actual, **FWA** in confidential files, which may only be released in accordance with applicable laws and CalOptima **Policies and Procedures**. All participants and attendees of CalOptima's Quality Improvement Committee, **Compliance Committee**, and respective subcommittees shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the **Compliance Program**, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the **Compliance Program** against the elements of an effective **Compliance Program** as recommended by **OIG** and required by **CMS** regulations. The following areas will be reviewed:

- **Policies and Procedures**;
- **Compliance Officer** and **Compliance Committee**;
- Training and education of **Board Members**, **Employees**, and **FDRs**;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal **Monitoring** and **Auditing**;
- **Delegation** oversight;
- **Exclusion** and **Preclusion** screening process; and
- Prompt responses to detected offenses.

The **Compliance Program** will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with **Executive Staff and Management**, the **Compliance Committee**, and the **CalOptima Board**. Updates to the **Compliance Program** will be based on the results of the evaluation and will be referred to the **CalOptima Board** for review and approval.

I.PRIVILEGED FILES AND DOCUMENT RETENTION

a. Privileged Files

All privileged files shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the **Compliance Officer**, CalOptima legal counsel, and the **Compliance Committee**, where appropriate, shall have access to its contents. All materials in the privileged file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. The privileged file shall contain the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the **Compliance Officer**;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning **FDR delegation** agreement interpretations and remedies available to CalOptima.

b. Document Retention

CalOptima shall retain contracts, books, documents, records, financial statements, and other data, as defined in Title 42, Code of Federal Regulations, Sections 438.5(c), 438.604, 606, 608, and 610, for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract (except for privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

CalOptima shall maintain the documentation required by **HIPAA** for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) **Policies and Procedures** (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by **HIPAA**; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under **HIPAA**; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A



Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste, and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste, and abuse. CalOptima is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of potential fraud, waste, and abuse and discuss employee and contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

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	Political Activities CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment

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	and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its physician groups, its health networks and third-party administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima policies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.

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Public Integrity CalOptima and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima policies. **Public Funds** CalOptima, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and employees shall comply with applicable law and CalOptima policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures.

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	Personnel Files Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima.

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	Third-Party Sponsored Events CalOptima's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima policies on this subject. In no event, shall CalOptima participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at contractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.

Principle	Standard
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, and gender expression), sexual orientation, health status, physical or mental disability, or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, physician groups, and health networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of employees, individuals and entities doing business with CalOptima by conducting regular exclusion and preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its health networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Principle	Standard
	Licensure CalOptima requires that all employees, contractors, health networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own policies in accordance with CalOptima's reporting policies and its Compliance Plan. Such reports may be made to a supervisor or the Compliance Officer. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's

Principle	Standard
	discretion, range from oral correction to termination in accordance with CalOptima's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or exclusion or preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, employees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable policies.

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Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a covered service for purposes other than the purpose for which it was described including use of such covered service.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.	Hotline reports; internal reports; reports by health networks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

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Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for covered services that are substantially and demonstrably in excess of any individual's usual charges for such covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for covered services that are in excess of the quantity that is medically necessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for covered services that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for covered services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for covered services that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for covered services.	Member report; hotline report; oversight audits.
P09	Billing a member for covered services without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits.
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.

P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight audit; report by regulatory body; hotline.
FDR FRAUD, WASTE OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
P13	False certification of medical necessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate minimum standards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; hotline report; oversight audits.
P20	Durable Medical Equipment- covered services that are not actually provided to member.	Member report; hotline report; oversight audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a member's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit" or "Auditing") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one (1) of several acknowledged certifications.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director of Audit & Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima Members" or "Members") means a beneficiary who is enrolled in a CalOptima program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima under contract with DHCS and CMS, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of **Executive Staff** that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, employees and FDRs comply with applicable law and ethical standards.

Compliance Risk Assessment ("CRA") A tool utilized to stratify level of risk (high, medium, low) based upon audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance

organizations licensed under the Knox-Keene Act, Health & Safety Code Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or **Employees** ("Employee" or "Employees") means any and all employees of CalOptima, including all Executive Staff, Management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

Exclusion ("Exclusion" or "Excluded") means suspension, exclusion, or debarment from participation in Federal and/or state health care programs.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

Executive Staff ("Executive Staff") means an employee whose position title is Chief, or Executive Director of one (1) or more departments.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State Health Care Programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care

services to a member under a CalOptima program.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

General Services Administration ("GSA") **System for Award Management** ("SAM") is a type of federal government exclusion database and contains the list of Excluded Parties List System (GSA-EPLS). The EPLS consists of federal contractors who have been debarred, sanctioned, or excluded due to government contract issues or fraud. The database is updated usually on a monthly basis.

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Immediate Corrective Action Plan ("ICAP") means the result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Management ("Management") means any employee whose position title is Director, Senior Manager, Manager, or Supervisor of one (1) or more departments.

Medi-Cal Suspended & Ineligible ("S&I") **Provider List** is a list of suspended and ineligible providers that is maintained by DHCS in the Medi-Cal Provider Manual. The list is updated monthly and available online and in print from DHCS.

Medicare Secondary Payer (MSP) Vendor means third-party vendors contracted to perform administrative functions with regards to the identification and recovery of monies owed to OneCare or OneCare Connect for recoupment of conditional payments. These administrative duties include, but are not limited to, the pursuit of repayments for third party liabilities and other health care coverage.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Multipurpose Senior Services Program ("MSSP") is a program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature

institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of Inspector General List of Excluded Individuals and Entities ("**OIG LEIE"**) is an exclusion list and contains individuals and/or entities that have been excluded from participation in federal healthcare programs such as Medicare and Medicaid. This list is usually updated on a monthly basis.

OneCare ("OneCare") is a Medicare Advantage Health Maintenance Organization (HMO) plan offered by CalOptima to provide Medicare covered benefits to Members.

OneCare Connect ("OneCare Connect") is a Medicare-Medicaid health plan offered by CalOptima that contracts with both Medicare and Medi-Cal to provide covered benefits of both programs to Members.

Overpayment ("Overpayment") means a payment disbursed in excess of amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating Providers and Suppliers ("Participating Providers and Suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its health networks for items or services furnished to members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima policies and procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board Members, employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs.

Personally Identifiable Information ("PII") means any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Pharmacy Benefit Manager ("PBM") means an entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written policies and procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Program of All-Inclusive Care for the Elderly ("PACE") is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

Preclusion ("Precluded" or "Preclusion List") is a type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Protected Health Information ("PHI") refers to the 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

Regulatory Agencies ("Regulatory Agencies") include, but are not limited to: Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG), and the Office of Civil Rights (OCR).

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.

Seniors and Persons with Disabilities ("SPD") means Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

Sub-delegation ("Sub-delegation") means the process by which a first tier entity expressly grants, by formal agreement, to a downstream entity the authority to carry out one or more functions that would

otherwise be required to be performed by the first tier entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an employee in a position representing CalOptima who has one (1) or more employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima employee that is the designated liaison for that contractor.

Third-Party Administrator ("TPA") means a contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org , or mail: CalOptima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for (existing FDRs) or sixty (60) calendar days for (new FDRs) of this notice.

Which CalOptima program(s) does this form pertain to? Select all that apply:	☐OneCare Connect ☐OneCare HMO SNP	☐Medi Cal ☐PACE

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and FWA Training**. Provide effective Fraud, Waste and Abuse training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records per CMS retention requirement)

☐ An internal training program that meets CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements. (The Organization shall maintain records per CMS retention requirement)
Note: If selecting an internal training program that meets CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers: (i) based on their job function within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change; (iii) when such persons work in an area previously found to be non- compliant with program requirements or implicated in past misconduct.

III. **Compliance Plan and Code of Conduct Requirements**. Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and

downstream entity board members, officers, employees, temporary employees, and

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volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization. (Select which applies to your organization):

- ☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct
- ☐ Organization has distributed a comparable Compliance Plan and Code of Conduct
  Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the (Suspended and Ineligible Provider List) S & I Medi-Cal, (Health and Human Services) HHS, (Office of Inspector General) OIG List of Excluded Individuals & Entities list, (System for Award Management) SAM/(General Services Administration) GSA Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (here after "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non- compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

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FDR Compliance Attestation

VIII **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non- compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

_____	_____
Signature	Date
_____	_____
Name (Print)	Organization
_____	
Email (Print)	

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Attestation Concerning the Use of Offshore Subcontractors

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org, or mail: CalOptima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days (existing FDRs) or sixty (60) calendar days (new FDRs) of the notice accompanying this form.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐OneCare Connect ☐OneCare HMO SNP	☐Medi Cal ☐PACE
Are any administrative or other functions conducted on behalf of your Organization by entities located offshore? <u>This shall include employees of your firm, subcontractors and any 3rd party subcontractors</u>. If **NO**, please **complete Part I** of this form If **YES**, please **complete Parts II–VI** of this form		☐Yes ☐No

Part I — Our Firm is Not Using Offshore Subcontractors and/or Employees	
Offshore subcontractors: Our Organization does not currently offshore subcontractors	☐Yes ☐No
Offshore employees: Our Organization does employ workers who are located offshore	☐Yes ☐No
Name of organization:	
Name of authorized person:	
Title:	
Signature:	
Date:	

Part II — Offshore Subcontractor Information	
Offshore employees: Our Organization does employ workers who are located offshore	☐Yes ☐No
Subcontractor name:	
Subcontractor country:	
Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor:	

Part III — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor and/or employee.	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's/employee's objectives	

3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected	

Part IV — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontractor/employee arrangement has policies and procedures in place to ensure that Medi-Cal and Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore subcontractor/employee arrangement prohibits subcontractor/employee access to Medi-Cal and Medicare data not associated with CalOptima's contract with the offshore subcontractor/employee.	☐Yes ☐No*
C. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected	☐Yes ☐No*
D. Offshore subcontractor/employee arrangement includes all required DHCS (Department of Health Care Services) and/or CMS (Centers for Medicare & Medicaid Services) language as stipulated within your contract with CalOptima	☐Yes ☐No*

*Explanation required for "no" response to Part IV items A to D above

Part V — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Your Organization will conduct an annual audit of the offshore subcontractor/employee.	☐Yes ☐No*
B. Audit results will be used by your Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐Yes ☐No*
C. Your Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima upon request.	☐Yes ☐No*
D. Our organization agrees to notify CalOptima at least 60 days in advance of our intent to use new offshore subcontractor(s) or before employing new offshore staff for a function CalOptima has asked us to perform.	☐Yes ☐No*

*Explanation required for "no" response to Part V items A to D above

Part VI — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/Vendors/FDRComplianceInformation.aspx

Policy ~~#:~~:	HH.2021Δ
Title:	**Exclusion and Preclusion Monitoring**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/~~12~~2012
~~Last Review Date:~~	~~12/06/18~~
~~Last~~ Revised Date:	~~12/06/18~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

FOR 2019 1205 BOD REVIEW

I. PURPOSE

This policy outlines a process for verifying and ~~monitoring~~**Monitoring** the eligibility of **Employees** (permanent, temporary, volunteer, and as-needed ~~employees~~**Employees**), members of the **Governing Body**, **First Tier, Downstream, and Related Entities (FDRs)**, non-contracted **Providers**, and vendors to participate in CalOptima federal and/or state health care programs through state and federal exclusions, **Preclusion**, and ineligible person/entity lists.

II. POLICY

A. CalOptima shall ensure all **Employees**, ~~members~~**Members** of the **Governing Body**, **FDRs**, non-contracted **Providers**, and vendors are eligible to participate in CalOptima federal and/or state health care programs, and shall be responsible for:

1. Requiring an **Employee**, ~~member~~**Member** of the **Governing Body**, **FDR**, non-contracted **Provider** or vendor to disclose and report pending suspensions, exclusions, **Preclusions**, or debarments, of the **Employee**, ~~member~~**Member** of the **Governing Body**, **FDR**, **Providers**, or vendor;

2. Conducting the initial eligibility verification of an **Employee**, ~~member~~**Member** of the **Governing Body**, **FDR**, non-contracted **Provider**, and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima, or issuing payment thereto;

3. Performing eligibility verification of an **Employee**, ~~member~~**Member** of the **Governing Body**, **FDR**, non-contractor **Providers**, and vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

B. CalOptima shall not employ individuals, or contract with individuals or entities that are determined to be suspended, debarred, precluded or ~~excluded~~**Excluded** from participation in federal or state health care programs.

C. CalOptima shall not reimburse, or make payment for services provided under the medical direction or on the prescription of an ~~excluded~~**Excluded** person or entity, or make payment to, an individual or entity that is verified to be suspended, debarred, precluded or ~~excluded~~**Excluded** from participation in federal or state health care programs.

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

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D. CalOptima will take immediate appropriate actions, with the assistance of its Legal Counsel, to terminate the employment of an individual, the contractual relationship with an **FDR** or vendor for all CalOptima programs, or the appointment of a ~~member~~**Member** of the **Governing Body**, if such individual or entity is verified to be suspended, debarred, precluded or ~~excluded~~**Excluded** from participation in federal or state health care programs.

E. CalOptima shall utilize state and federal **Preclusion**, exclusion, and ineligible person/entity list sources referenced in this policy to verify the eligibility of an **Employee**, ~~member~~**Member** of the **Governing Body**, **FDR**, non-contracted **Provider** or vendor and shall maintain a record of completion.

F. All CalOptima **FDRs** and vendors shall verify the eligibility of all its **Employees** and/or **Downstream Entities** prior to hiring/contracting/performing services and monthly thereafter. The **FDR** and vendors shall maintain a record of completion.

G. In the event a CalOptima **FDR**, or vendor identifies its Employees and/or Downstream Entities on an exclusion, **Preclusion**, and/or ineligible person/entity list, the **FDR** or vendor must immediately notify CalOptima of the identified ineligible person/entity. CalOptima in its sole discretion will determine whether it is appropriate to immediately remove/terminate the identified person/entity from furnishing items and services for CalOptima programs and/or terminate the applicable **FDR** or vendor contract.

H. The Office of Compliance may **Audit** CalOptima departments responsible for exclusion and **Preclusion** activities, as necessary.

III. PROCEDURE

A. Initial Verification

1. Prior to hiring an **Employee**, having an individual become a **Member** of the **Governing Body** or a CalOptima committee, or contracting with an **FDR** or vendor, or approving payment to a non-contracted **Provider** the responsible department identified in the chart in Section II.F. of this policy shall verify that the individual or entity is not **Excluded** or Precluded by reviewing the **Monitoring** sources to retrieve verification and eligibility data, including, but not limited to:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medi-Cal's Suspended and Ineligible (S&I) list;

   c. CMS **Preclusion** List;

   d. OIG Exclusions Database (OIG LEIE Database); and

   e. Other **Monitoring** sources as identified in CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

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B. Evidence of Verification

1. CalOptima shall utilize state and federal **Preclusion**, exclusion, and ineligible person/entity list sources referenced in this policy to verify the eligibility of an **Employee**, **Member** of the **Governing Body**, **FDR**, non-contracted **Provider** or vendor and shall maintain a record of completion indicating, at minimum:

   a. The date of verification;

   b. The exclusion, **Preclusion** and ineligible person/entity list source(s);

   c. Verification results; and

   d. The name of the person who conducted the verification.

2. CalOptima is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly exclusions and **Preclusions** checks thereafter.

Group	**Prior to contracting/hire, or payment if a non-contracted provider, CalOptima will verify through …**	**Monthly thereafter, CalOptima will verify through …**
Employees	• Human Resources	• Human Resources
Members of the **Governing Body** (Board of Directors)	• Human Resources	• Human Resources
CalOptima Committees	• Human Resources	• Human Resources
Pharmacy ~~Prescriber~~Prescribers	• ~~PBM~~Pharmacy Benefit Manager	• ~~PBM~~Pharmacy Benefit Manager
Pharmacy Network ~~Provider~~**Providers**	• ~~PBM~~Pharmacy Benefit Manager	• ~~PBM~~Pharmacy Benefit Manager
FDRs~~-~~, Vendors (excluding Medical **Providers** and **Health Networks**)	• Vendor Management	• Regulatory Affairs & Compliance
Medical **Providers**, Practitioners, Health Delivery Organizations (HDOs)	• Quality/**Credentialing** (contracted) • **Provider** Data Management Services (non-contracted)	• Quality/**Credentialing**
Health Networks	• Contracting	• Regulatory Affairs & Compliance
~~Medical Group Practice~~Medical Group Practices, physician medical groups, non-medical **Providers** and letter of agreements (LOAs)	• Contracting	• Quality/**Credentialing** • Regulatory Affairs & Compliance

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3. All CalOptima **FDRs** and vendors shall verify the eligibility of all its **Employees** and/or Downstream Entities (as defined above) prior to hiring/contracting/performing services and monthly thereafter. The **FDR** and vendors shall maintain a record of completion indicating, at minimum:

   a. Date of verification;

   b. The exclusion, **Preclusion** and ineligible person/entity list source(s);

   c. Verification results; and

   d. The name of the person who conducted the verification.

~~E. In the event an Employee, FDR, or vendor has been identified in an exclusion list, the FDR or vendor must immediately notify CalOptima of the identified ineligible person/entity. CalOptima will determine whether it is appropriate to immediately terminate the Employee, FDR, or vendor.~~

~~F. The Office of Compliance may **Audit** CalOptima departments responsible for exclusion activities, as necessary.~~

~~III. PROCEDURE~~

~~1. Monitoring Sources~~

~~1. As applicable, CalOptima shall use Monitoring sources to retrieve verification and eligibility data, including, but not limited to:~~

~~a. The General Services Administration's (GSA) System for Award Management (SAM) website;~~

~~a. Medicare Exclusion Database (MED);~~

~~b.a. Medi-Cal's Suspended and Ineligible (S&I) list;~~

~~c.a. OIG Exclusions Database (OIG LEIE Database); and~~

~~b. Other Monitoring sources as identified in CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.~~

~~B. Initial Verification~~

~~1. Prior to hiring an Employee, having an individual become a member of the Governing Body or a CalOptima committee, or contracting with an FDR or vendor, the responsible department identified in the chart in Section II.F. of this policy shall verify that the individual or entity is not Excluded by reviewing the Monitoring sources listed in Section III.A.1 of this policy.~~

C. **Monitoring**

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1. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor **Employees**, **FDRs**, non-contracted **Providers,** vendors, and ~~members~~**Members** of the **Governing Body** and committees by reviewing the **Monitoring** sources listed in Section III.A.1 of this policy.

~~2. The responsible department shall deem an Employee, member of the Governing Body or committee, FDR, or vendor excluded, or ineligible, if identified on one (1) or more Monitoring sources. If applicable, the Office of Compliance shall complete a CalOptima Provider Alert to notify all appropriate CalOptima departments of the excluded, or ineligible, individual, or entity.~~

D. Actions Based on Discovery of Exclusion

1. In accordance with Title 42, Code of Federal Regulations, Section 1001.1901(b)(1), CalOptima shall immediately suspend and halt payment for services for an ineligible, or ~~excluded~~**Excluded**, **Employee**, ~~member~~**Member** of the **Governing Body** or CalOptima committee, **FDR**, non-contracted **Provider,** or vendor~~.~~; or at the medical direction or on the prescription of a physician or an authorized individual who is excluded when the person furnishing such item or service knew, or had reason to know, of the exclusion. The payment prohibition applies regardless of whether ~~or not~~ the **Excluded** individual, or entity, submits claims for reimbursement to, or the method of reimbursement by, federal or state health care programs.

    a. The responsible department shall deem an **Employee**, **Member** of the **Governing Body** or committee, **FDR**, non-contracted **Provider** or vendor **Excluded**, or ineligible, if identified on one (1) or more **Monitoring** sources. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the **Excluded**, or ineligible, individual, or entity.
    b. The responsible department should refer the matter to the Office of Compliance for further investigation. As appropriate, the Office of Compliance may refer issues regarding the Excluded individual or entity to Legal Affairs for further action.
    c. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the ~~employment of an individual, the~~ contractual relationship for all CalOptima programs with a **FDR**, or vendor, or the appointment of a ~~member~~**Member** of the **Governing Body**, if such person, or entity, is determined to be **Excluded**. If the report identifies the removal of a suspended, **Excluded**, or terminated non-contracted **Provider** or **FDR** from CalOptima's **Provider** network, then the Office of Compliance shall report the action to DHCS within ten (10) business days and confirm that the **Provider** or **FDR** is no longer receiving payments in connection with the Medi-Cal program.
    ~~a.~~d. In the event, that ~~a specific FDR, or vendor, employee~~an **Employee** is identified as **Excluded**, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the ~~Excluded employee.~~**Employee**.

~~2. If CalOptima identifies an Excluded individual, or entity, after they are hired or contracted, the matter should be referred to the Office of Compliance for further investigation. As appropriate, CalOptima will engage in the service of Legal Counsel to take further action as appropriate. If the report identifies the removal of a suspended, excluded, or terminated Provider from CalOptima's Medi-Cal provider network, then the Office of Compliance shall report the action~~

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~~to DHCS within ten (10) business days and confirm that the provider is no longer receiving payments in connection with the Medi-Cal program.~~

~~a.~~c. CalOptima may recoup monies paid to the **Employee**, ~~member~~**Member** of the **Governing Body**, **FDR**, non-contracted **Provider,** **or** vendor while **Excluded**~~.~~ or Precluded. Exclusion and **Preclusion** findings will be referred to the Office of Compliance for further action in accordance with CalOptima policy. As appropriate, ~~CalOptima will engage in~~ the ~~service~~Office of Compliance may refer issues regarding the Excluded or precluded person to Legal ~~Counsel to take~~Affairs for further action~~, as appropriate.~~.

E. Actions Based on Discovery of **Preclusion**

1. In accordance with Title 42, Code of Federal Regulations, Sections 422.222, 422.224, 423.100, 423.120(c)(6), for precluded **Providers, FDRs,** or vendors, CalOptima may not reimburse or make payment for claims (i.e., for covered items or services) or prescriptions with any individual or entities on the **Preclusion** List, including for emergency or urgent care circumstances.
    a. The responsible department shall deem a **FDR,** non-contracted **Provider,** or vendor precluded if identified on the **Preclusion List**. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the **Precluded FDR,** non-contracted **Provider,** or vendor. CalOptima is also to notify the Health Networks to remove any contracted **Provider** and any contracted pharmacy found on the CMS **Preclusion** List from their network as soon as possible.
    b. CalOptima shall notify precluded **FDRs,** non-contracted **Providers** or vendors in writing that they can no longer treat **Members** and notify all impacted **Members**, including **Members** assigned to **Health Networks**, in writing who have received care or prescription from the precluded **FDR,** non-contracted **Provider,** or vendor in the last twelve (12) months as soon as possible, but no later than thirty (30) calendar days after the date the **FDR,** non-contracted **Provider,** or vendor was precluded. CalOptima will also remove the **FDR** or vendor from the Provider Directory no later than thirty (30) calendar days after the date the **FDR** or vendor was precluded.
    c. CalOptima will have thirty (30) days to review the **Preclusion** List and notify in writing impacted **Members**, including **Members** assigned to **Health Networks**, no later than thirty (30) calendar days from the posting of the updated list. Members should be given at least sixty (60) calendar days advance notice before payment denials and claims rejections begin.
    d. CalOptima should not deny payments and/or reject claims earlier than ninety (90) calendar days after publication of the associated **Preclusion** List.
    e. For **FDRs,** non-contracted **Providers**, or vendors identified on both the Exclusion sources and the CMS **Preclusion** List, CalOptima's processes for an **Excluded** individual or entity supersedes those of a precluded individual or entity.

~~E.~~F. **FDRs** and Vendors

1. If CalOptima ~~denies an~~intends to deny a prospective **FDR** or vendor participation in CalOptima program(s~~)~~), or terminate an existing **FDR's** or vendor's contract, on the basis of an Exclusion~~,~~

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or **Preclusion**, it shall notify the **FDR** or vendor, in writing, noting the reason for denial. ~~The~~The prospective or existing **FDR** or vendor may contest the denial if they feel there is an error or inappropriate exclusion. If CalOptima determines that there is an inappropriate exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issued June 29, 2011.

2. If ~~the~~an previously Excluded or precluded **FDR** or vendor has been re-instated by ~~an excludinga~~ Monitoring source listed on this policy~~,~~ and is now in good standing and able to participate in CalOptima federal and/or state health care programs, the **FDR** or vendor may express interest in participating with CalOptima. CalOptima will require evidence to verify ~~re-instated participation in CalOptima's~~reinstatement into federally- funded health care programs. In addition, the **FDR** or vendor will ~~require~~undergo re-processing through contracting and/or **Credentialing**.

~~IV. ATTACHMENTS~~
IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Medicaid Program Integrity Manual, Revised 2011
J. Medicare Program Integrity Manual, Chapter 4. Revised June 9, 2017
K. Sections 1128 and 156 of the Social Security Act
L. Title 42, Code of Federal Regulations (CFR.), §1001.1901
M. Title 42, United States Code (US.C), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
N. Title 42, Code of Federal Regulations, §§422.222, 422.224, 423.100, and 423.120(c)(6)
~~N.~~O. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

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

None to Date

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

~~A. 12/06/18: Regular Meeting of the CalOptima Board of Directors~~
~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors~~
~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors~~

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~~VIII.I. REVISION HISTORY~~

Date	Meeting
~~Date~~12/07/2017	Regular Meeting of the CalOptima Board of Directors~~Line(s) of Business~~
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Effective	05/01/2014	MA.9121	Exclusion Monitoring	OneCare
Revised	09/01/2015	HH.2021	Exclusion Monitoring	Medi-Cal
Revised	09/01/2015	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity (FTE)	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

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Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

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Policy:	HH.2021Δ
Title:	**Exclusion and Preclusion Monitoring**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/2012
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

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I. PURPOSE

This policy outlines a process for verifying and **Monitoring** the eligibility of **Employees** (permanent, temporary, volunteer, and as-needed **Employees**), members of the **Governing Body**, **First Tier, Downstream, and Related Entities (FDRs)**, non-contracted **Providers**, and vendors to participate in CalOptima federal and/or state health care programs through state and federal exclusions, **Preclusion**, and ineligible person/entity lists.

II. POLICY

A. CalOptima shall ensure all **Employees**, **Members** of the **Governing Body**, **FDRs**, non-contracted **Providers**, and vendors are eligible to participate in CalOptima federal and/or state health care programs, and shall be responsible for:

1. Requiring an **Employee**, **Member** of the **Governing Body**, **FDR**, non-contracted **Provider** or vendor to disclose and report pending suspensions, exclusions, **Preclusions**, or debarments, of the **Employee**, **Member** of the **Governing Body**, **FDR**, **Providers,** or vendor;

2. Conducting the initial eligibility verification of an **Employee**, **Member** of the **Governing Body**, **FDR**, non-contracted **Provider,** and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima, or issuing payment thereto;

3. Performing eligibility verification of an **Employee**, **Member** of the **Governing Body**, **FDR**, non-contractor **Providers,** and vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

B. CalOptima shall not employ individuals, or contract with individuals or entities that are determined to be suspended, debarred, precluded or **Excluded** from participation in federal or state health care programs.

C. CalOptima shall not reimburse, or make payment for services provided under the medical direction or on the prescription of an **Excluded** person or entity, or make payment to, an individual or entity that is verified to be suspended, debarred, precluded or **Excluded** from participation in federal or state health care programs.

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

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D. CalOptima will take immediate appropriate actions, with the assistance of its Legal Counsel, to terminate the employment of an individual, the contractual relationship with an **FDR** or vendor for all CalOptima programs, or the appointment of a **Member** of the **Governing Body**, if such individual or entity is verified to be suspended, debarred, precluded or **Excluded** from participation in federal or state health care programs.

E. CalOptima shall utilize state and federal **Preclusion**, exclusion, and ineligible person/entity list sources referenced in this policy to verify the eligibility of an **Employee**, **Member** of the **Governing Body**, **FDR**, non-contracted **Provider** or vendor and shall maintain a record of completion.

F. All CalOptima **FDRs** and vendors shall verify the eligibility of all its **Employees** and/or **Downstream Entities** prior to hiring/contracting/performing services and monthly thereafter. The **FDR** and vendors shall maintain a record of completion.

G. In the event a CalOptima **FDR**, or vendor identifies its Employees and/or Downstream Entities on an exclusion, **Preclusion**, and/or ineligible person/entity list, the **FDR** or vendor must immediately notify CalOptima of the identified ineligible person/entity. CalOptima in its sole discretion will determine whether it is appropriate to immediately remove/terminate the identified person/entity from furnishing items and services for CalOptima programs and/or terminate the applicable **FDR** or vendor contract.

H. The Office of Compliance may **Audit** CalOptima departments responsible for exclusion and **Preclusion** activities, as necessary.

III. PROCEDURE

A. Initial Verification

1. Prior to hiring an **Employee**, having an individual become a **Member** of the **Governing Body** or a CalOptima committee, or contracting with an **FDR** or vendor, or approving payment to a non-contracted **Provider** the responsible department identified in the chart in Section II.F. of this policy shall verify that the individual or entity is not **Excluded** or Precluded by reviewing the **Monitoring** sources to retrieve verification and eligibility data, including, but not limited to:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medi-Cal's Suspended and Ineligible (S&I) list;

   c. CMS **Preclusion** List;

   d. OIG Exclusions Database (OIG LEIE Database); and

   e. Other **Monitoring** sources as identified in CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

B. Evidence of Verification

1. CalOptima shall utilize state and federal **Preclusion**, exclusion, and ineligible person/entity list sources referenced in this policy to verify the eligibility of an **Employee**, **Member** of the

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Governing Body, **FDR**, non-contracted **Provider** or vendor and shall maintain a record of completion indicating, at minimum:

a. The date of verification;

b. The exclusion, **Preclusion** and ineligible person/entity list source(s);

c. Verification results; and

d. The name of the person who conducted the verification.

2. CalOptima is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly exclusions and **Preclusions** checks thereafter.

Group	Prior to contracting/hire, or payment if a non-contracted provider, CalOptima will verify through …	Monthly thereafter, CalOptima will verify through …
Employees	• Human Resources	• Human Resources
Members of the **Governing Body** (Board of Directors)	• Human Resources	• Human Resources
CalOptima Committees	• Human Resources	• Human Resources
Pharmacy Prescribers	• Pharmacy Benefit Manager	• Pharmacy Benefit Manager
Pharmacy Network **Providers**	• Pharmacy Benefit Manager	• Pharmacy Benefit Manager
FDRs, Vendors (excluding Medical **Providers** and **Health Networks**)	• Vendor Management	• Regulatory Affairs & Compliance
Medical **Providers**, Practitioners, Health Delivery Organizations (HDOs)	• Quality/**Credentialing** (contracted) • **Provider** Data Management Services (non-contracted)	• Quality/**Credentialing**
Health Networks	• Contracting	• Regulatory Affairs & Compliance
Medical Group Practices, physician medical groups, non-medical **Providers** and letter of agreements (LOAs)	• Contracting	• Quality/**Credentialing** • Regulatory Affairs & Compliance

3. All CalOptima **FDRs** and vendors shall verify the eligibility of all its **Employees** and/or Downstream Entities (as defined above) prior to hiring/contracting/performing services and monthly thereafter. The **FDR** and vendors shall maintain a record of completion indicating, at minimum:

a. Date of verification;

b. The exclusion, **Preclusion** and ineligible person/entity list source(s);

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c. Verification results; and

d. The name of the person who conducted the verification.

C. **Monitoring**

1. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor **Employees**, **FDRs**, non-contracted **Providers,** vendors, and **Members** of the **Governing Body** and committees by reviewing the **Monitoring** sources listed in Section III.A.1 of this policy.

D. Actions Based on Discovery of Exclusion

1. In accordance with Title 42, Code of Federal Regulations, Section 1001.1901(b)(1), CalOptima shall immediately suspend and halt payment for services for an ineligible, or **Excluded**, **Employee**, **Member** of the **Governing Body** or CalOptima committee, **FDR**, non-contracted **Provider,** or vendor; or at the medical direction or on the prescription of a physician or an authorized individual who is excluded when the person furnishing such item or service knew, or had reason to know, of the exclusion. The payment prohibition applies regardless of whether the **Excluded** individual, or entity, submits claims for reimbursement to, or the method of reimbursement by, federal or state health care programs.
    a. The responsible department shall deem an **Employee**, **Member** of the **Governing Body** or committee, **FDR**, non-contracted **Provider** or vendor **Excluded**, or ineligible, if identified on one (1) or more **Monitoring** sources. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the **Excluded**, or ineligible, individual, or entity.
    b. The responsible department should refer the matter to the Office of Compliance for further investigation. As appropriate, the Office of Compliance may refer issues regarding the Excluded individual or entity to Legal Affairs for further action.
    c. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the contractual relationship for all CalOptima programs with a **FDR**, or vendor, or the appointment of a **Member** of the **Governing Body**, if such person, or entity, is determined to be **Excluded**. If the report identifies the removal of a suspended, **Excluded**, or terminated non-contracted **Provider** or **FDR** from CalOptima's **Provider** network, then the Office of Compliance shall report the action to DHCS within ten (10) business days and confirm that the **Provider** or **FDR** is no longer receiving payments in connection with the Medi-Cal program.
    d. In the event, that an **Employee** is identified as **Excluded**, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the **Employee**.
    e. CalOptima may recoup monies paid to the **Employee**, **Member** of the **Governing Body**, **FDR**, non-contracted **Provider, or** vendor while **Excluded** or Precluded. Exclusion and **Preclusion** findings will be referred to the Office of Compliance for further action in accordance with CalOptima policy. As appropriate, the Office of Compliance may refer issues regarding the Excluded or precluded person to Legal Affairs for further action.

E. Actions Based on Discovery of **Preclusion**

1. In accordance with Title 42, Code of Federal Regulations, Sections 422.222, 422.224, 423.100, 423.120(c)(6), for precluded **Providers, FDRs,** or vendors, CalOptima may not reimburse or

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make payment for claims (i.e., for covered items or services) or prescriptions with any individual or entities on the **Preclusion** List, including for emergency or urgent care circumstances.

a. The responsible department shall deem a **FDR,** non-contracted **Provider,** or vendor precluded if identified on the **Preclusion List**. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the **Precluded FDR,** non-contracted **Provider,** or vendor. CalOptima is also to notify the Health Networks to remove any contracted **Provider** and any contracted pharmacy found on the CMS **Preclusion** List from their network as soon as possible.

b. CalOptima shall notify precluded **FDRs,** non-contracted **Providers** or vendors in writing that they can no longer treat **Members** and notify all impacted **Members**, including **Members** assigned to **Health Networks**, in writing who have received care or prescription from the precluded **FDR,** non-contracted **Provider,** or vendor in the last twelve (12) months as soon as possible, but no later than thirty (30) calendar days after the date the **FDR,** non-contracted **Provider,** or vendor was precluded. CalOptima will also remove the **FDR** or vendor from the Provider Directory no later than thirty (30) calendar days after the date the **FDR** or vendor was precluded.

c. CalOptima will have thirty (30) days to review the **Preclusion** List and notify in writing impacted **Members**, including **Members** assigned to **Health Networks**, no later than thirty (30) calendar days from the posting of the updated list. Members should be given at least sixty (60) calendar days advance notice before payment denials and claims rejections begin.

d. CalOptima should not deny payments and/or reject claims earlier than ninety (90) calendar days after publication of the associated **Preclusion** List.

e. For **FDRs,** non-contracted **Providers**, or vendors identified on both the Exclusion sources and the CMS **Preclusion** List, CalOptima's processes for an **Excluded** individual or entity supersedes those of a precluded individual or entity.

F. **FDRs** and Vendors

1. If CalOptima intends to deny a prospective **FDR** or vendor participation in CalOptima program(s), or terminate an existing **FDR's** or vendor's contract, on the basis of an Exclusion or **Preclusion**, it shall notify the **FDR** or vendor, in writing, noting the reason for denial. The prospective or existing **FDR** or vendor may contest the denial if they feel there is an error or inappropriate exclusion. If CalOptima determines that there is an inappropriate exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issued June 29, 2011.

2. If an previously Excluded or precluded **FDR** or vendor has been re-instated by a Monitoring source listed on this policy and is now in good standing and able to participate in CalOptima federal and/or state health care programs, the **FDR** or vendor may express interest in participating with CalOptima. CalOptima will require evidence to verify reinstatement into federally funded health care programs. In addition, the **FDR** or vendor will undergo re-processing through contracting and/or **Credentialing**.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

FOR 20191205BOD REVIEW

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Medicaid Program Integrity Manual, Revised 2011
J. Medicare Program Integrity Manual, Chapter 4. Revised June 9, 2017
K. Sections 1128 and 156 of the Social Security Act
L. Title 42, Code of Federal Regulations (CFR.), §1001.1901
M. Title 42, United States Code (US.C), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
N. Title 42, Code of Federal Regulations, §§422.222, 422.224, 423.100, and 423.120(c)(6)
O. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Effective	05/01/2014	MA.9121	Exclusion Monitoring	OneCare
Revised	09/01/2015	HH.2021	Exclusion Monitoring	Medi-Cal
Revised	09/01/2015	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised		HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

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2

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity (FTE)	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

FOR 2019 12/5 BOD REVIEW

Term	Definition
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

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FOR 20191205BOD REVIEW

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
13. Consider Approval of Homeless Health Initiatives Guiding Principles

Contact
Michael Schrader, Chief Executive Officer (714) 246-8400

Recommended Action
Approve Homeless Health Initiatives Guiding Principles and Crosswalk as a framework for future funding allocations.

Background
On April 4, 2019, the CalOptima Board of Directors committed expenditures of $100 million for Homeless Health Initiatives within a three-year period. At that time, $40 million was directed to a range of specific initiatives, including enhanced Medi-Cal services at the Be Well OC Regional Mental Health and Wellness Campus; recuperative care; clinical field team startup costs; CalOptima Homeless Response Team; and homeless coordination at hospitals. An additional $60 million was appropriated for future initiatives. At the special Board meeting on June 27, 2019, a proposal with funding allocations for the $60 million was approved. The funding allocations covered four areas: clinic health care services in all homeless shelters; authorize mobile health team to respond to all homeless providers; residential support services and housing navigation; and extend recuperative care for homeless individuals with chronic physical health issues. On September 5, 2019, staff received Board direction to develop Guiding Principles related to the $60 million allocation and to solicit input from Board members and providers on those principles.

The draft Homeless Health Initiatives Guiding Principles were shared with the Board on September 20, 2019, and a crosswalk of the Guiding Principles and funding categories was later integrated. Both documents were developed in coordination with the Board's ad hoc committee on homeless health. The draft Guiding Principles were also shared with the Orange County Medical Association, the Hospital Association of Southern California and CalOptima health networks. At the October 3, 2019, Board meeting, staff again received direction to bring the Guiding Principles to the full Board for consideration. On October 28, 2019, the California Department of Health Care Services released California Advancing and Innovating Medi-Cal (CalAIM), a proposal with the potential to significantly impact the future Medi-Cal delivery system framework, starting in 2021. Although the proposal is not yet finalized or approved by state and federal regulators, some tenets of CalAIM are designed to enhance services for high-needs populations, including homeless individuals. On November 7, 2019, the Board requested that staff consider the impact of CalAIM on the Guiding Principles, update the document if needed and present the information to the full Board.

Discussion
The Board recognizes that the approved $60 million allocation for the Homeless Health Initiatives allows room for flexibility to execute the new initiatives that are most impactful and relevant to our

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members experiencing homelessness. The staff developed the Homeless Health Initiatives Guiding Principles to refine the decision-making process, ensure investment in the most appropriate programs and to address provider concerns. Proposals consistent with the principles will be brought forward for consideration by the Board; proposals that are inconsistent will face revision or rejection. Proposals may also change depending on the status of CalAIM. Ultimately, the Board has full discretion on the allocation of funds. However, internal and external stakeholders will be able to use the Guiding Principles to support initiatives that unify the community around the shared goal of better serving Orange County's homeless population.

Fiscal Impact

The recommended action is budget neutral. The $60 million allocation has already been approved by the Board. The recommended action has the effect of distributing funds to various as yet undetermined initiatives, but the amount will not exceed $60 million.

Rationale for Recommendation

The above recommendation serves to guide funding allocations for CalOptima's Homeless Health Initiatives to ensure expenditures meet strategic priorities and have the most positive impact for members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Homeless Health Initiatives: Guiding Principles presentation
2. Homeless Health Initiatives Guiding Principles
3. Crosswalk: Guiding Principles and Homeless Health Funding Categories
4. CalAIM Appendix D

/s/ Michael Schrader *11/26/2019*
Authorized Signature Date

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CalOptima
A Public Agency
Better. Together.

Homeless Health Initiatives: Guiding Principles

Board of Directors Meeting
December 5, 2019

Michael Schrader, Chief Executive Officer
TC Roady, Director, Regulatory Affairs and Compliance
Candice Gomez, Executive Director, Program Implementation

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Agenda

- Current initiatives and Board direction
- California Advancing and Innovating Medi-Cal (CalAIM)
- Homeless Health allocation in light of CalAIM

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Current Initiatives

Board-Approved Programs With $100 Million Homeless Health Reserve	Funding
Be Well OC Regional Mental Health and Wellness Hub	$11.4 million
Recuperative Care	$10.75 million
Respite Care	$250,000
Clinical Field Team Startup	$1.6 million
CalOptima Homeless Response Team	$6 million
Homeless Coordination at Hospitals	$10 million
CalOptima Day and Quality Improvement Program	$1.2 million
Federally Qualified Health Centers Expansion	$.6 million
Total Allocated	**$41.8 million**
Remaining Funding Available	**$58.2 million**

- Other Board-Approved Programs Supporting Homeless Health
  - Medication-Assisted Treatment: $6 million (IGT funds)
- Other Programs Pending Board Approval
  - Housing Supportive Services: $2.5 million (reallocated from reserve)

Board Actions and Directives on Homeless Health

- In June, the Board adopted a $60 million allocation for homeless health spending in four categories
  - Clinic health care services in all homeless shelters
  - Mobile health team response to all homeless providers
  - Residential support services and housing navigation
  - Recuperative care for those with chronic physical health issues
- Working with the Board's ad hoc committee, staff developed Guiding Principles and crosswalk to provide the Board with a tool to guide funding decisions
- CalAIM has the potential to affect homeless health spending in the future
  - Consider CalAIM's impact on Guiding Principles

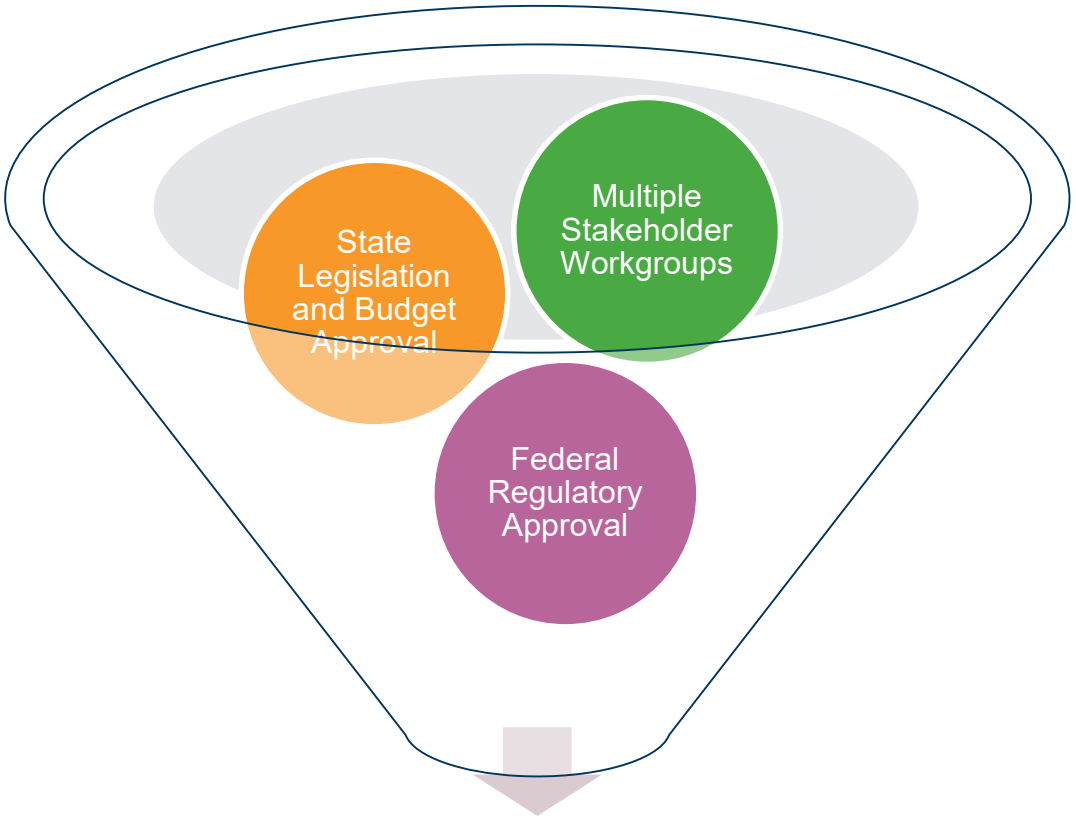
CalAIM Background

- On October 28, the Department of Health Care Services (DHCS) released CalAIM, a proposal with the potential to significantly impact the future Medi-Cal delivery system framework
  - Spans a five-year period from 2021 to 2025
  - Contains more than 20 core initiatives
  - Expands Medi-Cal managed care plans' responsibilities

- The proposal represents the start of a process that will include stakeholder engagement, and multiple federal and state approvals

CalAIM Process

- CalAIM is in the early stages of development
- CalAIM will evolve before reaching a final form for implementation starting January 1, 2021
  - ➢ Many layers of input will undoubtedly change the proposal



Final CalAIM Document

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Five CalAIM Workgroups

Population Health/ Annual Enrollment	• Requires managed care plans to develop and maintain population health management strategies
Enhanced Care Management	• Explores implementation of an enhanced care management benefit and in lieu of services
Behavioral Health	• Considers integration of county-level mental health and substance use disorder programs
NCQA Accreditation	• Provides input on a proposal to require Medi-Cal managed care plans to obtain accreditation
Full Integration Plans	• Discusses full integration of physical health, behavioral health and oral health under one entity

Future CalAIM Implementation

- The various proposals have different effective dates, ranging from January 2021 to January 2025
  - Understanding the rules and regulations before and after implementation will be challenging

- With regard to CalOptima's Homeless Health Initiatives, three proposals (in their current form) have the most potential impact in the near term
  - Population Health Management
  - Enhanced Care Management
  - In Lieu of Services

Current State, Before CalAIM

- Programs that “bridge” to CalAIM
  - Health Homes Program (HHP)
    - Enhanced care management
    - Housing supportive services
  - Whole-Person Care (WPC)
    - Recuperative care
- Intergovernmental Transfer (IGT) 1–7 dollars
  - Enhanced services for Medi-Cal members
    - Reallocating funds toward housing supportive services
- IGT 8 dollars
  - Medi-Cal-covered services for Medi-Cal members
    - Enhanced hospital discharge planning
    - Transitions of care (under development with stakeholder group)

Future Possibilities, After CalAIM*

- Population Health Management (PHM)
  - Develop and maintain PHM programs compliant with NCQA requirements, and update and file annually with DHCS
  - Risk stratify populations (low-, medium- and high-risk) and have defined actions and programs to address population needs
  - Conduct initial member assessments and then reassessments on an annual basis
  - Offer basic, complex and enhanced care management

**Subject to stakeholder input and CMS and DHCS approval*

Future Possibilities, After CalAIM* (Cont.)

- Enhanced Care Management (ECM) and In Lieu of Services (ILOS)
  - Statewide health plan benefit replacing HHP and WPC by January 1, 2021
  - Holistic, interdisciplinary approach to clinical and non-clinical needs of target populations
    - Individuals experiencing homelessness are specifically included as a target population
  - By July 2020, plans must submit transition plan moving from HHP and WPC to the ECM/ILOS model of care

**Subject to stakeholder input and CMS and DHCS approval*

Future Possibilities, After CalAIM* (Cont.)

- ILOS can only be covered if:
  - State determines that the service is a medically appropriate and cost-effective substitute for a typical service
  - The service is optional (beneficiaries are not required to use ILOS)
  - The service is authorized and identified in the state's Medi-Cal managed care plan contract

Menu of In Lieu of Services Options**
Housing transition navigation services
Housing deposits
Housing tenancy
Short-term post-hospitalization housing
Nursing facility transition/diversion
Recuperative care
Personal care and homemaker services
Respite care
Day habilitation programs
Home modifications
Meals/medically tailored meals
Sobering centers

***See CalAIM Appendix D for a detailed description of what is allowed under each of the above ILOS*

* *Subject to stakeholder input and CMS and DHCS approval*

CalAIM Advocacy

- California Association of Health Plans and Local Health Plans of California are actively participating in the CalAIM process
  - Managed care plans, including CalOptima, will be integral in shaping the eventual final CalAIM document
  - Managed care plans are generally very supportive of the direction CalAIM is headed

- Responding to the needs of Orange County's homeless population would be enhanced through adoption of certain current CalAIM proposals
  - CalOptima will advocate to this effect and pursue opportunities as available

Recommended Action

- Approve homeless health initiatives Guiding Principles and crosswalk as a framework for future funding allocations

HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES
December 5, 2019

Organizations across Orange County are actively responding to the local homeless crisis. CalOptima is participating by making improvements to the health care delivery system for homeless individuals. On April 4, 2019, the Board of Directors voted to commit $100 million in a restricted homeless health reserve. At that time, $40 million was directed to a range of specific initiatives, and $60 million was for unidentified new initiatives:

Projects *(as of April 4, 2019)*	**Allocated**	**Unallocated**	**Funding Category**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup Costs	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$6 million		IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)	$10 million		
New Initiatives		$60 million	
Total Reserve: $100 million	**$40 million**	**$60 million**	

In the months since, CalOptima has continued to consider program options, in part by welcoming input from community organizations and providers serving homeless individuals. On June 27, 2019, at a special Board meeting, the Board approved a proposal outlining $60 million in funding allocations for new homeless health initiatives as follows:

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

The Board recognizes that the approved allocations allow room for interpretation and the possibility of executing new initiatives in various ways. Further, a recent state proposal, known as California Advancing and Innovating Medi-Cal (CalAIM), suggests significant changes to the Medi-Cal managed care landscape starting in 2021. Although the proposal is not yet finalized or approved by state and federal regulators, some tenets of CalAIM are designed to enhance services for high-needs populations, including homeless individuals. To move forward with effective funding allocations in this dynamic environment, staff have developed Guiding

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Principles to refine decision making, ensure investment in the most appropriate programs and respond to provider concerns. Proposals consistent with the principles would be brought forward for consideration by the Board; proposals that are inconsistent would face revision or rejection. Proposals may also change depending on the status of CalAIM. Ultimately, the Board has full discretion, but internal and external audiences can use the principles to support initiatives that unify the community around our shared goal of better serving Orange County's homeless population.

GUIDING PRINCIPLES

Transparent and Inclusive

Inherent in CalOptima's response to the homeless crisis is a commitment to engage the community. Since beginning this effort and across several months, we have collaborated with Orange County Health Care Agency leaders, homeless advocates, community health center staff, provider representatives and countless others. CalOptima staff have and will continue to host meetings and forums, most recently adding a provider and hospital meeting series. Our interest in establishing these Guiding Principles starts from this place of inclusiveness.

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

Compliant and Sustainable

CalOptima has invested considerable time and money in understanding the legal and regulatory spending parameters related to health care delivery system enhancements for members who are homeless. In this environment, there are clear distinctions between funding sources that must be maintained. Intergovernmental Transfer (IGT) 1–7 dollars were permitted for enhancements to Medi-Cal services, but new IGT 8 dollars must be used according to different guidelines that restrict the spending to Medi-Cal-covered services. Furthermore, use of FY 2018–19 operating funds is similarly restricted to Medi-Cal-covered services for members, so expenditure of these dollars will be incorporated into CalOptima's rate development process. This would create sustainable funding for ongoing homeless health programs even after depletion of the Board-established homeless health reserve. However, the CalAIM proposal has the potential to expand Medi-Cal-covered benefits, which could broaden what CalOptima is permitted to fund for homeless health. This opportunity is under development, so until CalAIM is finalized, CalOptima must adhere to current rules. In any event, financial stewardship is one of CalOptima's core values, and our commitment is to spend on new homeless health initiatives in a fashion that complies with all applicable rules and appropriately builds our rates.

- *CalOptima shall spend the $60 million on allowable uses only, with the strict rule that IGT 8 and FY 2018–19 funds must be used for Medi-Cal-covered services for Medi-Cal members.*

Strategic and Integrated

CalOptima's effort to better serve members who are homeless is aligned with the strategic direction of state and federal regulators as well as industry trends. Population health initiatives recognize that certain populations need targeted interventions, and these programs can be integrated within the existing delivery system. For example, CalOptima's clinical field team program is designed to reconnect members with their medical homes not replace them. We appreciate the essential role of our hospital and health network partners and will purposefully seek ways to ensure new homeless health initiatives are integrated.

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

Defined and Accountable

CalOptima is in new territory exploring ways to respond to the needs of homeless members. But our commitment to longstanding principles of quality and accountability has not changed. As we move forward, new programs will be carefully defined through Board-approved actions and subject to appropriate oversight and performance metrics. The CalOptima Board will hold itself accountable to ensure the implemented programs provide value and perform as anticipated, which may include establishing incentives for provider partners.

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

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CROSSWALK: HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES AND FUNDING CATEGORIES

December 5, 2019

		Homeless Health Funding Categories			
		Clinic health care services in all homeless shelters	**Authorize mobile health team to respond to all homeless providers**	**Residential support services and housing navigation**	**Extend recuperative care for homeless individuals with chronic physical health issue**
Guiding Principles	**Transparent and Inclusive*** *Transparent planning that includes providers and other key stakeholders*	Consistent: Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.	Consistent: Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.	Consistent: CalOptima and our health networks transparently and inclusively provide Medi-Cal members with case management and care coordination as appropriate. In addition, health networks will serve as CB-CMEs for HHP, with Illumination Foundation as an available vendor for housing navigation. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program. Separately, the IHSS, MSSP and PACE programs provide services in the member's home.	Consistent: Today, recuperative care is not currently a Medi-Cal benefit, apart from the WPC pilot to which CalOptima previously allocated funds for recuperative care. However, CalOptima is planning to advocate with providers and stakeholders through the CalAIM process for the state to make recuperative care a Medi-Cal benefit in 2021, upon the completion of the WPC pilot.
		*Assumes continued coordination of input from biweekly health network/hospital meetings with CalOptima Board Homeless Health Ad Hoc.			
	Compliant and Sustainable *Sustained Medi-Cal funding for CalOptima from DHCS*	Consistent: Continuing to pay for clinic services (Medi-Cal-covered services) for CalOptima Medi-Cal members at shelters would be sustainable in terms	Consistent: Continuing to pay for clinical field team services (Medi-Cal-covered services) for CalOptima Medi-Cal members would be sustainable in	Consistent: Case management and care coordination are covered benefits under the basic Medi-Cal program, and housing navigation is a	Inconsistent: Inconsistent today because recuperative care is not a Medi-Cal-covered service, except through the WPC pilot. Consequently, there

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		of ongoing state funding.	terms of ongoing state funding.	covered benefit under HHP. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program. Consequently, there is sustainable funding within these parameters.	is no source of sustainable funding currently. However, the CalAIM process has the potential to broaden Medi-Cal-covered services to include recuperative care.
	Strategic and Integrated *Integration with CalOptima's contracted health care delivery system*	Consistent: Clinic services in homeless shelters should reconnect members with their medical homes (i.e., health networks and PCPs).	Consistent: Clinical field teams should reconnect members with their medical homes (i.e., health networks and PCPs).	Consistent: Case management and care coordination services are integrated into CalOptima's contracted health care delivery system. HHP CB-CMEs will also be integrated through health networks. The CalAIM proposal would sunset HHP and transition housing navigation to another program, which would also be integrated into the CalOptima system.	Consistent: If recuperative care becomes a Medi-Cal benefit following completion of the WPC pilot and/or implementation of CalAIM, CalOptima would integrate the benefit with our contracted delivery system of health networks and hospitals.
	Defined and Accountable *Specific deliverables and measures of success*	Consistent: Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	Consistent: Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	Consistent: There is definition and accountability for health networks related to case management, care coordination and HHP CB-CME housing services. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program, which would also be defined and accountable.	Consistent: If recuperative care becomes a Medi-Cal benefit, we will continue what the WPC pilot successfully started, including to have specific deliverables and measures of success (e.g., transitions to PSH).

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Acronyms:
CalAIM = California Advancing and Innovating Medi-Cal
CB-CME = Community-Based Care Management Entity
HHP = Health Homes Program
IHSS = In-Home Supportive Services
MSSP = Multipurpose Senior Services Program
PACE = Program of All-Inclusive Care for the Elderly
PCP = Primary Care Physician
PSH = Permanent Supportive Housing
WPC = Whole-Person Care

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Appendix D: Menu of In Lieu of Service Options

Following is the proposed menu of in lieu of services that would be covered under the CalAIM initiative. Each set of services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF)
- Nursing Facility Transition to a Home
- Personal Care (beyond In Home Services and Supports) and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers

Housing Transition Navigation Services

Description/Overview

Housing transition services assist beneficiaries with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8 or Section 202, etc.) and matching available rental subsidy resources to members.
7. If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. [1]
8. Assisting with requests for reasonable accommodation, if necessary.
9. Ensuring that the living environment is safe and ready for move-in.
10. Communicating and advocating on behalf of the client with landlords.

[1] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

11. Assisting in arranging for and supporting the details of the move.
12. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[2]
13. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
14. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Medi-Cal managed care plans must assure housing options identified for members are safe and appropriate for the member's health status.

The services may involve coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care (CoCs) through Coordinated Entry System; and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Services do not include the provision of room and board or payment of rental costs.

Eligibility (Population Subset)

Individuals who are matched to a permanent supportive housing unit or rental subsidy resource through the Coordinated Entry System or similar system designed to use clinical information to identify highly vulnerable individuals with multiple chronic conditions and/or serious mental illness and/or serious substance use disorder.

[2] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

Individuals who meet the Housing and Urban Development (HUD) definition of homeless[3] (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the HUD definition of homeless (including those exiting institutions but not including any limits on the number of days in the institution) and who have multiple chronic conditions and/or serious mental illness and/or serious substance use disorders. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness" which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth experiencing homelessness or with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system and have a serious mental illness and/or a child or adolescent with serious emotional disturbance.

Individuals who meet the definition of a Chronically Homeless Individual either as defined:

A. In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
B. By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 as:

[3] Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

1. A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
    i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
    ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;
2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Restrictions and Limitations

In lieu of services are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and cost-effective substitute or setting for the State Plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services are authorized and identified in the Medi-Cal managed care plan contracts.

Housing Transition/Navigation services are available once in an individual’s lifetime. Housing Transition/Navigation services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Transition/Navigation services would be more successful on the second attempt.

These services must be identified as reasonable and necessary in the individual’s individualized housing support plan and are available only if the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- Mental health or substance use disorder treatment providers;
- Supportive housing providers; and
- Federally qualified health centers.

Clients who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services they should be provided by one entity whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) to be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, Emergency Transport services, and skilled nursing facility services.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.

Individuals who are matched to a permanent supportive housing unit or rental subsidy resource through the Coordinated Entry System or similar system designed to use clinical information to identify highly vulnerable individuals with multiple chronic conditions and/or serious mental illness and/or serious substance use disorder.

Individuals who meet the Housing and Urban Development (HUD) definition of homeless[4] (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the HUD definition of homeless (including those exiting institutions but not including any limits on the number of days in the institution) and who have multiple chronic conditions and/or serious mental illness and/or serious substance use disorders. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness" which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth experiencing homelessness or with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system and have a serious mental illness and/or a child or adolescent with serious emotional disturbance.

Individuals who meet the definition of a Chronically Homeless Individual either as defined:

A. In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

[4] Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

B. By the Department of Housing and Urban Development (HUD) in 24 C.F.R. 91.5 as:

1. A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

    i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

    ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least four (4) separate occasions in the last three (3) years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven (7) consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Restrictions and Limitations

In lieu of services are alternative services covered under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. An in lieu of service can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

Housing Deposits are available once in an individual’s lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

The entity that is coordinating an individual's Housing Navigation/Transition Services, or the Medi-Cal managed care plan case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.)

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, Emergency Transport services, and skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance us, and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assistance with the annual housing recertification process.
8. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
9. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.
10. Health and safety visits, including unit habitability inspections.
11. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).
12. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

Services do not include the provision of room and board or payment of rental costs.

Eligibility (Population Subset)

Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.

Individuals who are matched to a permanent supportive housing unit or rental subsidy resource through the Coordinated Entry System or similar system designed to use clinical information to identify highly vulnerable individuals with multiple chronic conditions and/or serious mental illness and/or serious substance use disorder.

Individuals who meet the Housing and Urban Development (HUD) definition of homeless[5] (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the HUD definition of homeless (including those exiting institutions but not including any limits on the number of days in the institution) and who have multiple chronic conditions and/or serious mental illness and/or serious substance use disorders. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder

[5] Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness" which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth experiencing homelessness or with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system and have a serious mental illness and/or a child or adolescent with serious emotional disturbance.

Individuals who meet the definition of a Chronically Homeless Individual either as defined:

A. In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

B. By the Department of Housing and Urban Development (HUD) in 24 C.F.R. 91.5 as:

    1. A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

        i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

        ii. Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least four (4) separate occasions in the last three (3) years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven (7) consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

    2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other

similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically appropriate and cost-effective substitute or setting for the State Plan service 2) beneficiaries are not required to use the in lieu of services, and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.

Many individuals will have also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

Individuals may not be receiving duplicative support from other state, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- Mental health or substance use disorder treatment providers

- Supportive housing providers
- Federally qualified health centers

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

Clients who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, they should be provided by one entity whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, Emergency Transport services, skilled nursing facility services.

Short-term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides beneficiaries who are homeless and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric), substance abuse or mental health treatment facility, custody facility, or recuperative care.[6]

This setting provides individuals with ongoing supports necessary for recuperation such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition/Navigation.[7]

This setting may include supported housing in an individual or shared interim housing setting.

Beneficiaries must also receive Housing Transition/Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting.

Eligibility (Population Subset)

Individuals exiting recuperative care.

Individuals exiting an inpatient hospital stay (either acute or psychiatric), substance abuse or mental health treatment facility, or custody facility and who meet any of the following criteria:

- Individuals who meet the HUD definition of homeless[8] (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management. For the purpose of this service,

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[6] Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu service.

[7] Housing Transition/Navigation is a separate in-lieu service.

[8] Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

- Individuals who meet the HUD definition of homeless (including those exiting institutions but not including any limits on the number of days in the institution) and who have multiple chronic conditions and/or serious mental illness. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness" which includes persons exiting institutions who were homeless prior to entering the institutions and Transition-age youth experiencing homelessness or with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system and have a serious mental illness and/or a child or adolescent with serious emotional disturbance.

- Individuals who meet the definition of Chronically Homeless Individual either:

    a. As defined in W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

    b. As defined by the Department of Housing and Urban Development (HUD) in 24 C.F.R. 91.5 as:

        1. A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

            i. Lives in a place not meant for human habitation, a safe haven or in an emergency shelter; and

            ii. Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least

four (4) separate occasions in the last three (3)years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven (7) consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

In addition to meeting one of these criteria at a minimum, individuals must:

- Have medical/behavioral health needs such that experiencing homelessness upon discharge from hospital, substance abuse or mental health treatment facility, correctional facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission; and
- Participate in a housing assessment and individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.[9]

The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing and Trauma Informed Care.

[9] The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs).

The service is only available if enrollee is unable to meet such expense or when the services cannot be obtained from other sources.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Supportive Housing Providers

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, post-acute care, Emergency Department services, Emergency Transport services, skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with activities of daily living
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are homeless or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to clients onsite in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Are homeless or are at imminent risk of being homeless;
- Live alone with no informal supports; or
- Face housing insecurity or have housing that would jeopardize their health and safety without modification. [10]

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Recuperative care/medical respite is an allowable in lieu of services service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Examples of facilities include:

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support

[10] For this population, the service could be coordinated with home modifications (which are covered as a separate in lieu service) and serve as a temporary placement until the individual can safely return home.

- County directly operated or contracted recuperative care facilities

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, skilled nursing facility, and Emergency Department services.

Respite Services

Description/Overview

Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

The Home Respite benefit services are provided to the participant in his or her own home.

The Facility Respite benefit services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State

Plan. An in lieu of service can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.

Benefit limit is up to 336 hours per calendar year. The benefit is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336 hour annual limit.

This benefit is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Licensing/Allowable Providers

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children
- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency(FHA): Adult Family Home (AFH)/Family Teaching Home(FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs

- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, and Skilled Nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a participant's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For homeless participants receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers. When possible these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management

Day habilitation program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire or local services to support independence in the community.

Programs may include assistance with, but not limited to:

1. Selecting and moving into a home; [11]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords; [12]
5. Managing personal financial affairs;
6. Recruiting, screening, hiring, training, supervising and dismissing personal attendants;

[11] Refer to the Housing Transition/Navigation Services In Lieu of Services
[12] Refer to the Housing- Tenancy and Sustaining Services In Lieu of Services

7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support.
10. Coordination with Medi-Cal managed care plan to link participant to any in lieu of services and/or enhanced care management services for which the client may be eligible;
11. Referral to non-in lieu of services housing resources if participant does not meet Housing Transition/Navigation Services in lieu of services eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if client is not receiving these services through in lieu of services or enhanced care management; and
13. Coordination with Medi-Cal managed care plan to link participant to health care, mental health services, and substance use services based on the individual needs of the participant for participants who are not receiving this linkage through in lieu of services or enhanced care management.

The services provided should utilize best practices for clients who are homeless or formerly homeless including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 12 months, and individuals at risk of homelessness whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service is only provided to individuals age 21 and over. All medically-necessary case management services for children under the age of 21 are covered in the State Plan pursuant to the EPSDT benefit.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

- Non-Profit Agencies
- Licensed Psychologists
- Licensed Certified Social Workers
- Registered Nurses
- Home Health Agencies
- Professional Fiduciary

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, skilled nursing facility, Emergency Department services.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

DESCRIPTION/OVERVIEW

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs) Instrumental ADLs (IADLs), meals, transportation, medication administration and skilled nursing, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADL). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes:

1. Assessing the participant's housing needs and presenting options.[13]
2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF in order for the client to be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.

Eligibility (Population Subset)

[13] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.

A. For Nursing Facility Transition:
   1. Has resided 60+ days in a nursing facility;
   2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
   3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
   1. Interested in remaining in the community;
   2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
   3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive NF LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Individuals are directly responsible for paying their own living expenses.

Licensing/Allowable Providers

- Case management agencies
- Home Health agencies
- Managed care plans
- ARF/RCFE Operators

Medi-Cal managed care plan may utilize other providers but must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.

The RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home assists individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the participant's housing needs and presenting options.[14]
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord, if applicable and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[15]
7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations. [16]

[14] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.
[15] Refer to Home Modification In Lieu of Services for additional details.
[16] Refer to Housing Deposits In Lieu of Services for additional details.

Eligibility (Population Subset)

1. Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;
2. Has lived 60+ days in a nursing home;
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- Community Transition Services are furnished only to the extent that they are reasonable and necessary.
- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of $X, 000.00. The only exception to the $X,000.00 total maximum is if the participant is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare and safety of the participant, and without which the participant would be unable to move to the private residence and would then require continued or re-institutionalization.

Licensing/Allowable Providers

1. Case management agencies
2. Home Health agencies

3. Managed care plans

Medi-Cal managed Care plan may utilize other providers but must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal Managed Care plans shall monitor the provision of all the services included above.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management.

Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired.

Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.

In lieu of services can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (member must be already referred to In-Home Supportive Services), up to a maximum of 30 days, if required for immediate member need.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Similar services available through In-Home Supportive Services should always be utilized first. These PCA and Homemaker in lieu of services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility
- Individuals with functional deficits and no other adequate support system
- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This benefit cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a member has any change in their current condition, they must be referred to In-Home Supportive Services for assessment and determination of additional hours before the plan can begin to cover via in lieu of services.

Licensing/Allowable Providers

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, skilled nursing facility.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist beneficiaries in accessing the home;
- Doorway widening for beneficiaries who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary; and
- Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision.

The services are available in a home that is owned, rented, leased or occupied by the individual. For a home that is not owned by the individual, the individual must provide written consent from the owner for the modifications.

When authorizing environmental accessibility adaptations as an in lieu of service, the managed care plan must receive and document:

1. The participant's current primary care physician's order specifying the requested equipment or service;
2. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:
    A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;

B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant *and reduces the risk of institutionalization*. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and

C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.

3. Depending on the type of adaptation or modification requested, documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary;
4. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor and applicable warranties; and
5. That a home visit has been conducted to determine the suitability of any requested equipment or service.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- This benefit is not meant to replace any other State Plan service. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- Bathroom and bedroom modifications are limited to one of each of those types of rooms in a given house, and entryway modifications are limited to one entryway.

- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of the modification, the MCO must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for removal of any modification if the participant ceases to reside at the residence.
- Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

- The Medi-Cal managed care plan may manage these services directly or may coordinate with an existing Medi-Cal provider to manage the service.
- All EAAs must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.
- Area Agency on Aging (AAA) can provide these services.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to nursing facility services.

Meals/Medically Tailored Meals

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction.

1. Meals delivered to the home: immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
2. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.

Eligibility (Population Subset)

1. Individuals with chronic conditions: diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, and chronic or disabling mental health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with intensive care coordination needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Three medically-tailored meals per day for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Reimbursement to address food insecurities is not covered.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

- Licensing/Allowable Providers
- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly-intoxicated (alcohol and/or drug) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, and homeless care support services.

- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers.
- The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This benefit is covered for a duration of less than 24 hours.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

- Sobering Centers, or other appropriate and allowable substance use disorder facilities
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, Emergency Transportation services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

14. Consider Authorizing Reallocation of Intergovernmental Transfer Funds Previously Allocated for Recuperative Care to Housing Supportive Services; Consider Authorizing Contract(s) and/or Contract Amendment(s) with the County of Orange for Implementation

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize reallocation of $2.5 million from the $10 million previously allocated IGT 6 and 7 funds of the total of $11 million allocated for recuperative care and medical respite program to housing supportive services for CalOptima Medi-Cal members;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to
    a. Amend CalOptima's current agreement with the County of Orange as necessary to allow for reallocation of funds previously allocated to recuperative care for CalOptima members under the County's Whole Person Care (WPC) Pilot Program; and
    b. Enter into a new agreement or amend CalOptima's current agreement with the County of Orange to include housing supportive services for qualifying CalOptima members.

Background

The WPC Pilot is an Orange County-operated pilot program, administered by the Orange County Health Care Agency (OCHCA), that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. The County of Orange's WPC Pilot application was approved by the Department of Health Care Services (DHCS) in October 2016 and coordinates physical, behavioral health, and social services in a patient-centered approach with the goals of improved and health and well-being through more effective use of resources. The WPC Pilot provides housing supportive services which includes housing navigation and tenancy sustaining services. Additional funding was provided to the WPC Pilot in January 2019 allocating funds specifically to expand existing WPC housing navigation and supportive services for persons living with serious mental illness as well as implement these services for persons who do not have a connection to OCHCA Behavioral Health Services. The WPC Pilot also includes provisions for recuperative care services for up to a maximum of 90 days based on medical need. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. DHCS approved use of IGT 6 and IGT 7 funds to provide enhanced services to CalOptima Medi-Cal members in the following areas: opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the

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safety net, children's health, older adult health and other areas as identified by a member health needs assessment.

During the August 2, 2018 CalOptima Board of Directors (Board) meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. While community proposals were solicited, the Board made a grant allocation of up to $10 million from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for CalOptima members experiencing homelessness under the County's WPC Pilot in addition to the $1 million earlier allocated for recuperative care for CalOptima members experiencing homelessness and being discharged from a hospital setting. On April 4, 2019 the Board authorized reallocation of $250,000 from the $10 million IGT 6 and 7 recuperative care fund towards a Medical Respite Program for CalOptima Medi-Cal members meeting medical criteria beyond the 90 days available for recuperative care through the WPC Pilot.

On October 28, 2019 DHCS released the initial CalAIM proposal. While this proposal may be further refined prior to implementation, as proposed, it could significantly impact the future Medi-Cal delivery system. One proposed impact would be for Medi-Cal managed care plans, including CalOptima, to provide recuperative care as an In Lieu of Service potentially beginning as soon January 1, 2021. The County of Orange has determined that of the $9.75 million IGT 6 and 7 funding allocated by the CalOptima Board towards recuperative care, at least $2.5 million dollars can be reallocated toward other services without impacting the availability of recuperative care services for CalOptima members.

Discussion

Housing supportive services encompass housing navigation and sustaining services that include client assessments to identify barriers to housing placement and working with both landlords and members to sustain tenancy. Housing supportive services are incorporated into the member's individualized care plan that integrates all physical, behavioral, and social service needs. This member-centric supportive approach assists the individual to integrate into community-based settings which enhances their ability to be a good neighbor to the rest of the community.

The County of Orange provides housing supportive services to those who quality for the WPC Pilot and/or are linked to the County's Behavioral Health Services Program; however, there continue to be individuals who do not quality for services through these programs. In November 2019, OCHCA established a funding pool which is intended to address funding gaps for those needing but not receiving housing supportive services. In order to support these efforts, CalOptima staff recommends reallocating up to $2.5 million in IGT 6 and 7 funds previously allocated for recuperative care for CalOptima members to housing supportive services for CalOptima members. As proposed, these reallocated IGT 6 and 7 funds would be available to reimburse the OCHCA for housing supportive services provided to CalOptima members receiving services through WPC once WPC funding has been exhausted, or for CalOptima members not receiving services through WPC but in need of housing supportive services. CalOptima members enrolled in the Health Homes Program would be excluded as CalOptima is

coordinating with OCHCA to develop a separate agreement for members enrolled in the Health Homes Program.

The County of Orange contracts with vendors to provide housing supportive services. Services contracted vendors are required to provide, when appropriate, include but are not limited to the following:

- Match WPC clients with a housing voucher to appropriate housing resources or provide navigation services to those who do not have housing vouchers;
- Act as a liaison in collaboration with and between the WPC client and landlord;
- Transport or arrange for transportation of WPC clients to potential housing placement opportunities;
- Assist with the housing application process;
- Secure reasonable letters of support as needed;
- Ensure that the WPC client has a security deposit for housing and utilities;
- Ensure that the WPC client becomes a resident after housing placement;
- Arrange for utilities to be turned on;
- Educate WPC clients on housekeeping issues and "good neighbor" issues such as maintenance, community living, and independent living skills;
- Coach WPC clients in order to have successful interactions when meeting with potential property managers, and prepare them for placement; and
- Link WPC clients to peer mentoring and other sustainability services for ongoing support in an effort to further ensure housing sustainability.

Contracted housing supportive services vendors are approved and reimbursed for six months on a per member per month capitated basis. Individuals are reevaluated every six months and services continue until it is determined that the individual no longer requires housing supportive services. As proposed, CalOptima would reimburse the County for housing supportive services provided to qualifying CalOptima members on a per member per month basis.

Fiscal Impact

The recommended actions to authorize reallocation of up to $2.5 million in IGT 6 and 7 funds to housing supportive services for qualifying CalOptima members has no fiscal impact to CalOptima's Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, collaborates with our provider, community, and county partners to address the healthcare needs of CalOptima members and work to improve the availability, access, and quality of health care services.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
3. CalOptima Board Action dated April 4, 2019, Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program
4. California Advancing and Innovating Medi-Cal (CalAIM) Executive Summary

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

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Attachment to December 5, 2019 Board of Directors Meeting - Agenda Item 14

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
County of Orange	405 W 5th Street, suite 756	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

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On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

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funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

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Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working "Better. Together." CalOptima, as the community health plan for Orange County, is committed to working with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

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- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

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These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

/s/ Michael Schrader — **Authorized Signature**

9/25/2015 — **Date**

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IGT Progress Report and Proposal

Board of Directors Meeting

October 1, 2015

Lindsey Angelats

Dir, Strategic Development

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IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

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Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements



- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

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Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

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Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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Attachment to December 5, 2019 Board of Directors Meeting -- Agenda Item 14

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

Contacts

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the establishment of a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the Orange County Health Care Agency (OCHCA) Whole Person Care Pilot (WPC) program; staff to return to the Board for approval of implementing policies, and obtaining state approval, as appropriate;
2. Authorize reallocation of $250,000 to fund the Medical Respite Program from the $10 million previously allocated IGT 6/7 funds for recuperative care in support of the OCHCA WPC program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services for qualifying homeless CalOptima members who have exhausted available recuperative care days under the WPC program.

Background

The WPC is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. DHCS approved use of IGT 6 and IGT 7 funds to support programs addressing the following areas: Community health investments which may include programs addressing opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the safety net, children's health, older adult health and other areas as identified by a member health needs assessment. At the August 2, 2018 Board of Directors meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. A grant allocation of up to $10 million was approved from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for homeless CalOptima members under the WPC

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pilot. The funds are currently designated for funding 50 percent of medically justified recuperative care bed days up to a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available. The CalOptima Board of Directors also approved an amendment of the agreement with the County of Orange to include indemnity language and allowing for use of the allocated funds for recuperative care services under the County's WPC Pilot program for qualifying homeless CalOptima members.

Discussion

Since 2016, the OCHCA has collaborated with CalOptima and other community-based organizations, community clinics, hospitals, and county agencies to design and implement the WPC Pilot program. The recuperative care element of the WPC pilot is a critical component of the program. During calendar year 2018, the WPC recuperative care program provided services to 487 unique CalOptima members experiencing homelessness. Between August and December 2018, the average length of stay for these individuals was 34 days, at a cost of $705,250.

As part of evaluating the progress of the WPC pilot program, it has been identified though discussions with OCHCA that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy but do not qualify for transition to skilled nursing care, may benefit from medical respite care beyond the 90 days of recuperative care.

To address this concern, CalOptima staff, with the support of OCHCA WPC staff, and consistent with the approved IGT 6/7 funding categories, is proposing to develop a Medical Respite Program for CalOptima members who need extended medical care beyond the 90 days as provided under the current scope of the WPC Pilot to achieve and maintain medical stability. Staff is in the process of developing policies related to the proposed medical respite program, the purpose of which is to provide short-term residential care to allow individuals with unstable living situations the opportunity to rest in a safe and clean environment while accessing medical care and other supportive services. In addition to providing post-acute care and clinical oversight, medical respite care seeks to improve transitional care for the population and to aid in ending the cycle of homelessness while also gaining stability with case management relationships and programs. As appropriate, staff will seek state approval of this new Medical Respite Program, which is intended to support homeless CalOptima members as they recover and attain medical stability, or in the case of members in hospice, to receive services in a stable environment care. The additional time beyond the days available through the County's WPC program is intended to reduce inappropriate and/or avoidable utilization of hospital Emergency Departments, inpatient admissions and re-admissions.

CalOptima Members nearing the end of their available recuperative days in the WCP program will be evaluated on a case-by-case basis and will need approval by County WPC staff, County Medical Safety Net (MSN) program nurses and CalOptima to be eligible for the Medical Respite Program. Regular reviews and updates will be conducted by the MSN program nurses to ensure that 1) Members do not stay longer than appropriate and 2) Members receive appropriate care to achieve and maintain medical

stability and steps to move to a skilled nursing facility (SNF), if appropriate. It is anticipated that approximately two members per month will meet criteria to receive medical respite care. CalOptima will monitor utilization and member outcomes.

In addition, staff is seeking authority to reallocate $250,000 out of the $10 million the Board allocated to OCHCA WPC program for recuperative care to fund the Medical Respite Program. In other words, no new funding is being proposed. Instead, the recommendation for authority is to redirect dollars previously committed for recuperative care for homeless CalOptima members in coordination with the County's WPC program. Staff is also seeking authority to provide the OCHCA with reimbursement for the full cost of the Medical Respite Program stay at $120 per day, for all bed days beyond the WPC Pilot recuperative care program, not to exceed the requested reallocation amount of $250,000. The OCHCA supports the recommended actions and plans to continue to invoice CalOptima for members in the Medical Respite Program via a similar process such as the already established invoicing process for recuperative care. The funds will be available through the end of the WPC Pilot or until the funds are exhausted, whichever comes first.

Fiscal Impact

The recommended actions to authorize the creation of a Medical Respite Program for CalOptima members and to authorize a reallocation of $250,000 from the $10 million IGT allocation to Orange County Health Care Agency (OCHCA) for recuperative care services, previously approved by the Board on August 2, 2018, has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
2. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

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On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

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funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

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Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working "Better. Together." CalOptima, as the community health plan for Orange County, is committed to working with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

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- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

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These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

/s/ Michael Schrader — **Authorized Signature**

9/25/2015 — **Date**

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IGT Progress Report and Proposal

Board of Directors Meeting

October 1, 2015

Lindsey Angelats

Dir, Strategic Development

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IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

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Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements



- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

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Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

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Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

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Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

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- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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California Advancing and Innovating Medi-Cal (CalAIM)
Executive Summary

The Department of Health Care Services (DHCS) has developed a framework for the upcoming waiver renewals that encompasses broader delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population. This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that target social determinants of health and reduce health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and puts the focus on improving outcomes for all Californians. Attaining such goals will have significant impact on an individual's health and quality of life, and through iterative system transformation, ultimately reduce the per-capita cost over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are initial proposals whose implementation will ultimately depend on whether funding is available.

Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations as well as state-level statutory and policy changes. During this time, the DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on the needs of the beneficiary, some may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.). As one would expect, need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and

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align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

To achieve such outcome, CalAIM proposals offer the solutions to ensure the stability of Medi-Cal program and allows the critical successes of waiver demonstrations such as Whole Person Care, the Coordinated Care Initiative, public hospital system delivery transformation, and the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees. CalAIM seeks to build upon past successes and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive array of health and social services spanning all levels of intensity of care, from birth to end of life. To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and make system changes necessary to close the gap in transitions between delivery systems, opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles. For the purposes of CalAIM DHCS built off and refined those principles to guide the work we intended to pursue.

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities or inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

Key Goals

To achieve such principles, CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

The reforms of CalAIM are comprehensive and critical to the success of the delivery system transformation necessary to improve the quality of life for Medi-Cal members as well as long-term cost savings/avoidance that will not be possible to achieve absent these initiatives. Furthermore, these reforms are interdependent and build off one another; without one, the others are not either possible or powerful. Below is an overview of the various proposals and recommendations that make up CalAIM.

Identify and Manage Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the State's health care delivery system aimed at achieving better care, better health and reduced expenditures in Medi-Cal programs. In line with these objectives, DHCS is proposing reforms that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, as well as chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve such goals, DHCS proposes the following recommendations that focus on a whole-person care approach that addresses the needs of our beneficiaries across the board – looking at physical and behavioral as well as social determinants of health, with the overarching goals of improving quality of life and reducing the overall costs for the Medi-Cal population.

- Require plans to submit local population health mangement plans.
- Implement new statewide enhanced care management benefit.
- Implement in lieu of services (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement incentive payments to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.
- Evaluate participation in Institutions for Mental Disease Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver.
- Require screening and enrollment for Medi-Cal prior to release from county jail.
- Pilot full integration of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for foster care children and youth.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a patient-centered population health strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall include, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;

- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care pilots, and transitions those pilots to this new statewide benefit to provide a broader platform to build on positive outcomes from those programs.

Target populations include, but are not limited to:

- High utilizers with frequent hospital or emergency room visits/admissions;
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions;
- Individuals at risk for institutionalization, eligible for long-term care;
- Nursing facility residents who want to transition to the community;
- Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis);
- Individuals transitioning from incarceration; and
- Individuals experiencing chronic homelessness or at risk of becoming homeless.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under Whole Person Care, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a managed care plan will integrate into its population health strategy. These services are provided as a substitute, or to avoid, other services such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with Case or Care Management for members at high levels of risk and may fill gaps in state plan benefits to address medical or social determinants of health needs. Examples of in lieu of services include but are not limited to: housing transition and sustaining services, recuperative care, respite, home and community based wrap around services for beneficiaries to transition or reside safely in their home or community, and sobering centers.

The use of in lieu of services are voluntary, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building an integrated managed long-term services and supports (MLTSS) managed care program by 2026 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the State must use its ability to provide our Medi-Cal managed care plans with financial incentive payments established to drive plans and providers to invest in the necessary

delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

Institutions for Mental Disease (IMD) Expenditure Waiver

Currently, federal Medicaid funding cannot be used for institutional services provided to individuals with serious mental illness or severe emotional disturbance (known as the IMD exclusion). However, the federal government has developed an opportunity for states to seek the ability to receive federal funding for institutional services provided to these populations. Through extensive stakeholder engagement, DHCS will assess state and county interest in pursuing the IMD expenditure waiver, as well as readiness of our systems to achieve the required goals and outcomes. Such a proposal must be budget neutral and would allow counties to "opt-in." The main elements of any proposed waiver would include:

- Ensuring quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this waiver opportunity, counties that "opt in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail

Justice involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs are met like housing, transportation and overall integration back into the community. Studies have shown, such coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. In an effort to ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate the county inmate pre-release Medi-Cal application process by January 2022. Additionally, DHCS is proposing to mandate all counties implement warm-handoffs from county jail release to county behavioral health departments when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial

considerations due to realignment and Prop 30 implications. Given the complexity of this proposal, DHCS assumes the selected plans would not go live until 2024, as DHCS and our managed care plans and county partners work together to develop the most appropriate delivery systems for this purpose.

Develop a Long-Term Plan for Foster Care

In 2020, DHCS would like to form a group of stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. Based on the recommendations from such workgroup, DHCS, California Department of Social Services, and other sister departments would work to implement such changes based on timelines developed in the stakeholder process.

Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services are different depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental and other county based services.
To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance accredited
- Implement annual Medi-Cal health plan open enrollment
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Revisions to behavioral health inpatient and outpatient medical necessity criteria for children and adults
- Administrative behavioral health integration statewide
- Regional contracting
- Substance use disorder managed care program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle and Silver Diamine Fluoride for young children
- Pay for Performance for adult and children preventive services and continuity of care through a Dental Home

County Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contract and demographic information

Managed Care

Managed Care Enrollment

By January 2021, DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries and by January 2023 requiring all dual beneficiaries, statewide to be enrolled mandatorily in a managed care plan, with the exception of those for whom managed care enrollment does not make sense due to limited scope of benefits or limited time enrolled. This will eliminate variation of managed care enrollment practices that currently vary by aid code, population, or geographical location.

Standardize Managed Care Benefit

By January 2021, DHCS proposes to standardize managed care plans benefits, so that all Medi-Cal managed care plans provide the same benefit package. Some of the most significant changes are the carving-in of institutional long-term care and major organ transplants into managed care statewide and, per Executive Order, the carving out of pharmacy.

Transition to Statewide Managed Long-Term Services and Supports

In order to achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative to standardized mandatory enrollment of dual eligibles into a Medi-Cal managed care plan for Medi-Cal benefits and integration of long-term care into managed care for all Medi-Cal populations statewide. This will be done in two phases:

January 2021: The Coordinated Care Initiative proceeds as today, however Multipurpose Senior Services Programs will be carved out and all institutional long-term care services will be carved into managed care for all populations enrolled in plans around the state. DHCS will also implement the voluntary in lieu of services benefit at this time.

January 2023: Full transition of the Coordinated Care Initiative to mandatory managed care enrollment of dual eligibles into managed care in all counties/plan models. In addition, require Medi-Cal managed care plans to operate Medicare Dual-Special Needs Plans, in order to offer dual eligible members the ability to have coordinated managed care plans for both their Medi-Cal and Medicare benefits.

The purpose of these transitions and phases is to target a long-term goal of implementing managed long term services and supports (MLTSS) statewide in Medi-Cal managed care beginning in 2026 by providing enough time and incentive to develop the needed infrastructure. This will allow beneficiaries to receive needed MLTSS and home and community based services statewide through their managed care plan, instead of a variety of 1915(c) waivers that currently have capped enrollment and are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their subcontractors (delegated entities) to be National Committee for Quality Assurance (NCQA) accredited by 2025. DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain State and federal Medicaid requirements.

Annual Medi-Cal Health Plan Open Enrollment

Effective for plan enrollment as of January 1, 2022, DHCS proposes to implement an Annual Health Plan Open Enrollment process for all managed care plan enrollees. Enrollees would generally only be allowed to change their managed care plan during the Annual Health Plan Open Enrollment period which is consistent with health care industry practice. The Annual Health Plan Open Enrollment period would first begin in November 2021. However in recognition of the concerns previously raised by stakeholders, DHCS has developed this proposal to include a consumer-friendly exemption process that will allow members who have a real need to change plans mid-year to do so in a streamlined way. Enrollment into Medi-Cal coverage would still be allowed throughout the year. This proposal provides the stability required to do effective care and case management of the plan members, while still allowing a simplified process to allow a plan change when it is needed.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model, this also coincides with a shift of the rating period from the state fiscal year to the calendar year beginning in 2020. The proposal to move to regional rates has two main benefits. The first benefit is a decreased number of distinct actuarial rating cells that are required and submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS with goal of allowing DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates will allow cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging rather than just the experience of plans within the county. This change is fundamental to the ability of DHCS to implement the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps forward to invest in and improve access to mental health and substance use disorder services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS, and we recognize that the full needs of the Medi-Cal population are not being met, particularly with respect to improving services and access for children and other vulnerable populations. In order to achieve true reform, DHCS believes that an important first step is undergoing behavioral health payment reform, where DHCS will

transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. Such a shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation and engage in value-based payment arrangements with their health plan partners in order to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to further build a high quality continuum of care for mental health and substance use disorder services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services. DHCS is proposing to modify the medical necessity criteria in order to align with state/federal requirements and more clearly delineate and standardize the benefit statewide.

Administrative Behavioral Health Integration Statewide

Research indicates that approximately 50% of individuals who have a serious mental illness have a co-occurring substance use disorder and that those individuals benefit from integrated treatment. The State provides Medi-Cal covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, which makes it difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties participating in mental health and substance use disorder managed care are subject to two separate annual quality assessments, two separate post payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, counties providing integrated treatment to a Medi-Cal beneficiary must document the substance use disorder service separately from the specialty mental health service. The purpose of this proposal is to make necessary state and county changes that would provide substance use disorder and specialty mental health services through one delivery system.

Behavioral Health Regional Contracting

DHCS recognizes that some counties have resource limitations often due simply to their size and the number of beneficiaries residing in their county. Therefore, DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources

should consider opportunities for regional partnership. Furthermore, DHCS is interested in discussing how counties not currently seeking substance use disorder managed care participation may be more interested in doing so through a regional approach and/or how services provided under substance use disorder fee-for-service might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.

Substance Use Disorder Managed Care Program Renewal and Policy Improvements

DHCS proposes to incorporate the Drug Medi-Cal Organized Delivery System (also known as substance use disorder managed care) into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health managed care plans, and substance use disorder managed care plans. The expenditure authority for residential treatment provided in an Institution for Mental Disease will continue to be authorized through Section 1115 waiver authority. DHCS also intends to provide counties with another opportunity to opt-in to participate in the substance use disorder managed care program in hopes of promoting statewideness. Finally, DHCS is exploring opportunities to improve the substance use disorder managed care program based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying or changing policies to support the goal of improved beneficiary care and administrative efficiency.

Dental

The Department has set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. In order to progress towards achieving that goal, and based on our lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide:

- Add new Dental Benefits based on the outcomes and successes from the Dental Transformation Initiative that will provide better care and align with national dental care standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high risk and institutional populations; and
- Continue and expand Pay for Performance Initiatives initiated under the Dental Transformation Initiative that reward increasing the use of preventive services and establishing/maintaining continuity of care through a Dental Home. These expanded initiatives would be available statewide for children and adult enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office as identified in a recent audit. This proposal will also ensure that DHCS is compliant with federal and State requirements. These enhancement will be done in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 child beneficiaries. The State delegates certain responsibilities for these high-risk children to California's 58 counties. The State needs to enhance the oversight of counties to ensure they comply with legislation, regulations, and State issued guidance. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the State, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable State and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

For more detailed descriptions of the CalAIM proposals please refer to the full CalAIM document located on CalAIM page of the DHCS website.

Advancing Key Priorities

These reforms are interdependent and build off one another; without one, the others are neither possible or powerful.

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other. These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value based and integrated delivery of care are significantly harder and potentially impossible to achieve. These fundamental financing changes themselves would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Therefore, carving out prescription drugs from managed care (Medi-Cal Rx) and the other carve-in/carve-outs detailed in the Medi-Cal managed care proposals are necessary and serve as the foundation for DHCS to institute the concepts around not only regional rate setting, but also nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the

possibility of future full integration pilots). The Medi-Cal program has evolved over the multiple decades since inception and has relied upon ever-increasing system and fiscal complexity in order to operate and serve the Californians who rely upon it. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be the most effective with respect to the funding utilized to most efficiently operate the program.

Furthermore, CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medicaid can easily integrate, complement and catalyze the Administration's plan to impact the State's homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more integrated systems of care and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission. Furthermore, CalAIM will advance a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for kids, proliferating the use of value-based payments across our system, including in behavioral health and long-term care. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services including specialty mental health and substance use disorder services, Medi-Cal eligibility, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if enacted and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal. CalAIM proposes enhanced care management and in lieu of services benefits (such as housing transitions, respite and sobering centers) that address the clinical and non-clinical needs of high-cost Medi-Cal beneficiaries, through a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how Californians (adults and children) will access specialty mental health and substance use disorder services. It aligns the financing structure of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, eligibility for, and access to integrated behavioral health care.

Vulnerable Children: CalAIM would provide access to enhanced care management for medically complex children to ensure they get their physical, behavioral, developmental and oral health needs met. It aims to identify innovative solutions for providing low-barrier,

comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children including identifying the complex impacts of trauma, toxic stress and adverse childhood experiences by, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

Justice Involved: The Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health and non-clinical social services for justice-involved individuals prior to and upon release from county jails. These efforts will support scaling of diversion and reentry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for felons incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services would allow the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide by 2026. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and should be a critical component on the State's Master Plan on Aging.

From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. In addition, given that California has significant learnings from our past 1115 Waivers, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with new federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

The proposal outlines all elements of the Medi-Cal 2020 waiver and how they will be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or abilities to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes under this federal authority approach. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85%

of all Medi-Cal beneficiaries receive care, to be brought into the main fold of managed care. We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost effectiveness, of the Medi-Cal/Medicaid program.

CalAIM Stakeholder Engagement

DHCS' intention in the release of these proposals is to garner important input from the many key stakeholders and partners that help us to improve upon these concepts and align them with the expertise and experience of our partners. As previously outlined, DHCS will be undertaking a significant stakeholder engagement effort that begins with the release of this document and continues through the CalAIM workgroups scheduled for November through February, the Stakeholder Advisory Committee (SAC) and Behavioral Health SAC meetings, Medi-Cal Health Advisory Panel (MCHAP) and other convenings. We recognize that CalAIM contains many significant proposals and changes to the Medi-Cal program, aimed at ultimately improving the beneficiary experience and outcomes. However, these represent DHCS' initial proposals and thinking and we look forward to working to refine and modify these proposals relying on the expertise of our stakeholder partners through this engagement process. DHCS plans to finalize all proposals for submission to CMS in the May to July period of 2020 based on the input we will receive from our partners through this process, but also dependent on the funding availability through the state budget process

Conclusion

CalAIM is an ambitious but necessary proposal to positively impact our beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.

- Creates a fundamental shift in how Californians (adults and children) will access mental health and substance use disorder services including administration of, eligibility for, and access to integrated behavioral health care.

- Provides access to enhanced care management for medically complex children and adults to ensure they get their physical, behavioral, developmental and oral health needs met.

- Builds capacity in clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail.

- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and will be a critical component on the State's Master Plan on Aging.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
15. Consider Approval of CalOptima's 2020-2022 Strategic Plan

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
1. Adopt CalOptima's 2020-2022 Strategic Plan; and
2. Direct the Chief Executive Officer (CEO) to implement the strategic plan and provide regular progress reports to the Board of Directors over the course of its implementation.

Background/Discussion
CalOptima's 2017-2019 Strategic Plan will expire at the end of the 2019 calendar year. At the April 4, 2019 meeting, the Board approved a contract with Chapman Consulting to provide consulting services related to the CalOptima 2020-2022 Strategic Plan development activities.

Chapman Consulting's work to support the development of the 2020-2022 Strategic Plan included reviewing the current and previous strategic plans and conducting interviews with members of the CalOptima Board of Directors, chairs and co-chairs of the CalOptima Advisory Committees (Member Advisory Committee, OneCare Connect Member Advisory Committee, Whole-Child Model Family Advisory Committee and Provider Advisory Committee) and Executive staff. It also included facilitation of a full-day Board of Directors planning session and development of an Environmental Scan. These efforts were utilized to develop the substance of the draft strategic plan in accordance with Chapman Consulting's scope of work.

While developing the draft strategic plan, Chapman Consulting also facilitated a discussion at a joint meeting of CalOptima's Advisory Committees, as well as at a meeting with CalOptima's contracted Health Networks. The feedback received at those meetings was incorporated into the draft plan.

As a result of the efforts and feedback received, the following priority areas were identified and supported:

- Innovate and Be Proactive
- Expand CalOptima's Member Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

On November 7, 2019, an Information Item, including the draft Strategic Plan, was presented during the Board of Directors meeting. Staff is now recommending final approval of the 2020-2022 Strategic Plan. Upon approval by the Board of Directors, staff will finalize the graphic design for publication of the 2020-2022 Strategic Plan consistent with CalOptima branding guidelines.

The priority areas will support planning and development of CalOptima programs and initiatives over the course of the next few calendar years. These will include, for example, development of the

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expenditure plan for intergovernmental transfer funds expected during Fiscal Year 2020 and upcoming quality initiatives. Staff will begin to seek stakeholder input and return to your Board for approval of the expenditure plans, as appropriate.

Fiscal Impact
The recommended action to authorize CalOptima's 2020-2022 Strategic Plan is a budgeted item. The CalOptima Fiscal Year 2019-20 Operating Budget, approved by the CalOptima Board of Directors on June 6, 2019, included $50,000 to fund this action.

Rationale for Recommendation
Development of the proposed Strategic Plan is consistent with the direction provided by the Board of Directors to support planning and development of CalOptima programs and initiatives during 2020-2022.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima's 2020-2022 Strategic Plan
2. Board Action dated April 4, 2019 Consider Authorizing Contract with Vendor for Consulting Services Related to Strategic Plan 20202-2022
3. Board Information Item dated November 7, 2019 including the CalOptima Draft Strategic Plan 2020-2022 dated October 28, 2019 and Final CalOptima 2020- 2022 Strategic Plan Environmental Scan dated September 19, 2019

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

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CHAPMAN
CONSULTING

CalOptima Strategic Plan 2020-2022

DOCUMENT PENDING GRAPHIC DESIGN

BY:
ATHENA CHAPMAN & CAROLINE DAVIS
NOVEMBER 15, 2019

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Message from CEO

Like many of you, I consider the beginning of the new 2020 decade as an opportunity to look ahead and to plan. So, it is the perfect time to launch CalOptima's next Strategic Plan, for 2020–2022. The guidance it offers and the priorities it sets have been carefully considered by a wide variety of leaders, including our Board of Directors, advisory committee members, executive staff, community stakeholders and industry consultants. Collaboration strengthens our plan and reflects our Better. Together. approach to quality health care for Orange County's vulnerable low-income residents.

If this decade is anything like the last, the one constant will be change. Recognition of this fact is central to the content of CalOptima's Strategic Plan. An overview of the health care landscape explains the federal, state and local drivers of change, followed by our strategic priorities and objectives in this environment.

Responding effectively in dynamic conditions does not mean CalOptima will alter our mission or vision, both of which are focused on members. Our commitment to members is as strong as ever, and you will see that dedication underlying all the priority areas, from innovation and community partnerships to value, quality and operational excellence. While we may adjust our efforts along the way in response to regulatory changes or community needs, we will not waver about putting members first.

And one final comment about 2020 — it's CalOptima's 25th anniversary year. We celebrate you and all the providers, community-based organizations, elected officials and stakeholders who partner with us. Together, we have accomplished so much, including statewide recognition year after year as a leading Medi-Cal health plan. Our shared goal of a healthier Orange County has brought us far and will carry us confidently into the future.

Michael Schrader
Chief Executive Officer

About CalOptima

CalOptima's Mission

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

CalOptima's Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members

Products

Medi-Cal (California's Medicaid Program): For low-income children, adults, seniors and persons with disabilities.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan): For people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits. Also included are benefits for

worldwide emergency care, dental care, vision care and fitness benefits. Other benefits are transportation to medical services and a Personal Care Coordinator.

OneCare (HMO SNP): A Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. Benefits are covered in one single plan, making it easier to get health care.

Program of All-Inclusive Care for the Elderly (PACE): A long-term comprehensive health care program that helps older adults remain independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community. PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal.

As of September 30, 2019, CalOptima has approximately 730,000 enrollees[i]: **(to be converted to pie chart in final version)**

- Medi-Cal: 711,968
- OneCare Connect (Cal MediConnect): 14,186
- OneCare: 1,564
- PACE: 356

Health Insurance Coverage in Orange County

CalOptima covers over 20% of Orange County residents.[ii]

Current Health Insurance Coverage Type	Orange County
Uninsured	6.7%
Medicare & Medicaid (Dual Eligibles)	3.0%
Medicare	11.2%
Medicaid	19.1%
Employment-based	51.8%
Privately Purchased	7.5%
Other Public Coverage	0.7%

CalOptima Profile[iii]

Members by Age (to be converted to pie chart in final version):

- Age 0-18 40%
- Age 19-64 48%
- Age 65+ 12%

Low Administrative Costs:

CalOptima spends nearly 96 cents of every dollar on member care and only 4 cents on program administration, which reinforces our commitment and mission as a community health plan that provides cost-effective quality health care services in a compassionate manner.

Provider Network Composition:

CalOptima has a strong provider network, which includes the contracted health networks, to serve our members:

- 1,567 primary care providers
- 6,944 specialists
- 40 acute and rehab hospitals
- 35 community health centers
- 570 pharmacies
- 100 long-term care facilities
- 5 PACE alternate care settings

High-Quality Care:

CalOptima offers high-quality care to our members:

- For five years in a row, CalOptima was the top rated Medi-Cal plan in California, according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings (2014-2019).
- For 2019-2020, no other health plan received a higher rating.
- NCQA has awarded an accreditation status of Commendable to CalOptima Medi-Cal.

Health Care Landscape Review

CalOptima's 2020-2022 Strategic Plan reflects the need to be responsive to a wide variety of federal, state and local priorities, considerations and issues. The landscape review is a summary of highlights from a comprehensive Environmental Scan that was completed to inform the Strategic Plan.

Federal Landscape

At the federal level, the policy landscape has been characterized by uncertainty for the last three years, and this is expected to continue for the foreseeable future. The Centers for Medicare and Medicaid Services (CMS), which provides the federal funding for, and oversight of, California's Medi-Cal program, has established a set of strategic priorities focused on driving innovation, implementing patient-centric approaches, and demonstrating results that improve care and lower costs. CalOptima will look to CMS's goals to prioritize development of innovative approaches that are aligned with the federal government. In addition, federal immigration policy may negatively impact Medi-Cal enrollment.

State Landscape

Within California, the health policy landscape is in transition with the election of Governor Newsom in November 2018. Governor Newsom has an ambitious health care agenda focused on expanding coverage for all Californians and reigning in costs. Within the California Department of Health Care Services (DHCS), key initiatives are underway that will shape the future of the Medi-Cal program and impact CalOptima's work over the next three years.

Medi-Cal Vision: 2021 and Beyond

The current federal Section 1115 Medicaid waiver, referred to as Medi-Cal 2020, expires at the end of 2020. As part of renewing the waiver, DHCS has launched a major restructuring of Medi-Cal, known as California Advancing and Innovating Medi-Cal (CalAIM), which is designed to reduce the complexity of the program, focus on population health and increase the use of value-based purchasing strategies. CalOptima will contribute to the CalAIM discussions and, ultimately, to the implementation of Medi-Cal's next chapter.

Prescription Drug Carve-Out

On his first day in office, Governor Newsom signaled his intent to address rising pharmacy costs by shifting to bulk purchasing of prescription drugs for all government programs, including Medi-Cal (the largest purchaser in the state). CalOptima will continue to work closely with DHCS on the design of the carve-out to minimize the impacts on our members and their health.

Future of the Coordinated Care Initiative and Cal MediConnect

The Coordinated Care Initiative (CCI) focuses on integrating delivery of medical, behavioral and long-term services and supports (MLTSS) benefit into California's Medi-Cal care delivery system. The CCI also includes the Cal MediConnect (CMC) duals demonstration, combing Medicare and Medi-Cal into a single program. CCI and CMC are currently operating in only seven counties and the federal authority for CMC is scheduled to sunset on December 31, 2022. As part of the CalAIM initiative, DHCS has proposed that all Medi-Cal managed care plans, including CalOptima, be required to operate a Dual-eligible Medicare Advantage Special Needs Plan (D-SNP) by January 1, 2023 and assume responsibility for all Medi-Cal long-term care services effective January 1, 2021. CalOptima will engage with DHCS and CMS on the CCI andCMC transitions.

Orange County Landscape

CalOptima is an integral part of the business community and the health care sector in Orange County. As the sole Medi-Cal plan in the County, CalOptima is in a unique position to impact care delivery and partner with County agencies and other stakeholders to improve access to care and quality for all members.

Homelessness and Behavioral Health

In Orange County, as across the state, the population of individuals experiencing homelessness has increased significantly over the past few years. Orange County has focused on developing a system of care that recognizes a multi-faceted approach is necessary to respond to the needs of County residents experiencing homelessness. CalOptima has committed $100 million to fund homeless health programs in the County; for example, CalOptima is funding programs in collaboration with its community health centers to provide members on-call medical services care in the field and increased preventive and primary care at shelters, establishing an internal homeless response team, supporting hospital discharge coordination, recuperative care and respite care.

In 2018, local public and private stakeholders came together to work on behavioral health issues. Under this initiative, known as Be Well OC, a regional wellness center will be constructed in Orange County to serve individuals with mental health needs regardless of payor source. CalOptima is participating in this

collaborative by pre-paying for services at the Be Well OC wellness center. Be Well OC is part of the larger Mind OC initiative to integrate behavioral health services across silos to address social determinants of health.

CalOptima Workforce Needs

CalOptima will continue to face an extremely competitive employment environment over the next three years. The high cost of living in Orange County coupled with the County's low unemployment rate, staff retirements and turn-over contribute to a tight labor market.

Physician Networks and Access to Care

Across California, there are concerns about access to care, the rising cost of living, and a lack of physicians and other health workers. These issues are particularly acute in the Medi-Cal program. To address access issues, CalOptima will continue to develop stronger networks with innovative value-based payment arrangements over the next three years.

Strategic Plan Development Process

To develop our 2020-2022 Strategic Plan, we gathered input from a wide range of CalOptima stakeholders:

- CalOptima's Board members, Executive Team and Advisory Committee leaders were interviewed to gather feedback about the current strategic plan as well as the issues and challenges facing the health plan over the next three years.
- Then, we held a Strategic Planning Session with the Board to review the findings from the interviews and to identify and discuss the priorities for the next strategic plan given the health care landscape in which CalOptima operates.
- Following the Strategic Planning Session, we held a joint meeting of all the Advisory Committees to solicit their input on the strategic priorities. We also convened Health Network representatives to gather their input on the next strategic plan.
- The draft 2020-2022 Strategic Plan was presented to the Board on **November 7**, 2019 for review and discussion.
- The final 2020-2022 Strategic Plan was adopted by the Board on **Month ##,** 2019.

Strategic Priorities & Objectives

Our members are the essential focus of the Priorities and Objectives for the 2020-2022 Strategic Plan and are supported by the programs and services provided by CalOptima.

Innovate & Be Proactive

- Anticipate Likely CMS And DHCS Priorities
- Identify and Collaborate on Local Priorities and Needs
- Leverage New Federal and State Programs and Services to Improve Access and Quality of Care for Members
- Seek Opportunities to Further Integrate Care for Members

Expand CalOptima's Member-Centric Focus

- Focus on Population Health
- Strengthen Provider Network and Access to Care
- Enhance Member Experience and Customer Service

Strengthen Community Partnerships

- Increase Collaboration with Providers and Community Stakeholders to Improve Care
- Utilize Strong Advisory Committee Participation to Inform Additional Community Engagement Strategies

Increase Value and Improve Care Delivery

- Evaluate and Implement Value-Based Purchasing Strategies that Drive Quality
- Deploy Innovative Delivery Models to Address Social Determinants of Health and Homelessness
- Maintain Focus on Providing High-Quality Care Provided to Members

Enhance Operational Excellence and Efficiency

- Maintain Strong Culture of Compliance
- Preserve CalOptima's Financial Stability
- Invest in Infrastructure and Efficient Processes
- Engage Workforce and Identify Development Opportunities

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[i] Source: CalOptima Fast Facts, Available at: https://www.caloptima.org/en/About/AboutCalOptima/FastFacts.aspx

[ii] Source: CHIS, 2017 California Health Interview Survey data. Available at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Consider Authorizing Contract with Vendor for Consulting Services Related to CalOptima's Strategic Plan 2020-2022

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions

1. Approve recommended consultant Chapman Consulting for consulting services for the CalOptima Strategic Plan 2020-2022 activities;
2. Authorize the Chief Executive Officer (CEO) with the assistance of Legal Counsel to enter into an agreement with the recommended consulting organization; and
3. In the event CalOptima and Chapman Consulting are unable to reach agreeable contract terms within thirty (30) days, authorize the CEO, with the assistance of Legal Counsel, to enter into an agreement with the next qualified bidder, Pacific Health Consulting Group for consulting services for the CalOptima Strategic Plan 2020-2022 activities.

Background

At the February 7, 2019, CalOptima Board of Directors meeting, staff presented an Informational Item on the Year 2 Progress Report of CalOptima's 2017-2019 Strategic Plan and a Planning Process for CalOptima's 2020-2022 Strategic Plan.

The 2017-2019 Strategic Plan will expire at the end of the 2019 calendar year. Following CalOptima's competitive bidding process in accordance with CalOptima Policy GA.5002: Purchasing, staff initiated a Request for Proposal (RFP) on January 9, 2019, for consulting services for the CalOptima 2020-2022 Strategic Plan activities.

Discussion

On February 20, 2019, CalOptima received seven (7) RFP responses for strategic planning consulting services from the following organizations:

- Chapman Consulting
- Curt Pringle & Associates
- Medecision, Inc.
- Milliman, Inc.
- Optum
- Pacific Health Consulting Group
- Spring Street Exchange

The submitted proposals were reviewed by an evaluation team consisting of representatives from Strategic Development, Government Affairs, Program Implementation, Health Network Management, Vendor Management and Customer Service. Additionally, the top two vendors (Chapman Consulting and Pacific Health Consulting Group) were invited for an interview.

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The recommended consultant will help facilitate several activities, including, but not limited to: review of CalOptima's previous Strategic Plan and specified data; interviews and planning sessions with members of CalOptima's Board of Directors executive level staff, and CalOptima Advisory Committees; engagement with key stakeholders; develop a draft of the Strategic Plan; and present a final plan to the Board of Directors.

Vendor	Final Weighted Score
Chapman Consulting	19.15
Pacific Health Consulting Group	11.25

Based on the final weighted scores, staff recommends contracting with Chapman Consulting for consulting services for the CalOptima Strategic Plan 2020-2022 activities in an amount not to exceed $81,950.

Chapman Consulting, LLC was established in January of 2018 as an independent consulting firm. Prior to establishing an independent consulting firm, the principal of Chapman Consulting, Ms. Athena Chapman, previously worked with the California Association of Health Plans (CAHP) as the Vice President of State programs. Ms. Chapman also worked with the Center for Medicare & Medicaid Services (CMS) as well as at the Department of Health Care Services (DHCS). Chapman Consulting has expertise in health care policy, delivery, administration, and financing and specific expertise in the Medi-Cal program. The proposed consultant has worked with health plans that provide coverage in the commercial market, the Covered California healthcare exchange and Medicaid and has a strong track record of building relationships between the government, providers, purchasers, vendors, and other stakeholders. Chapman Consulting can take complex health policy issues and provide succinct and relevant policy analysis and program recommendations. The proposed consultant also has extensive experience with meeting facilitation and has successfully developed several strategic and project-based plans for health care organizations. Chapman Consulting provides strategic planning, meeting facilitation, organizational support, and regulatory and statutory analysis, to a variety of health care related organizations. Chapman Consulting recently worked with the Coalition of Orange County Community Health Centers.

In the event CalOptima cannot reach agreeable contract terms with Chapman Consulting within thirty (30) days of CalOptima providing a response to any proposed contract change, staff recommends the Board of Directors authorize a similar process with Pacific Health Consulting Group and attempt to reach agreement on contract terms within a thirty (30) day timeframe.

Upon completion of the contracted work, the consulting organization will provide CalOptima and the Board of Directors with an updated organizational Strategic Plan for 2020-2022.

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Fiscal Impact

The recommended action to authorize an agreement for consulting services for the CalOptima Strategic Plan 2020-2022 activities has no additional fiscal impact for the current fiscal year. The CalOptima Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018 included $50,000 for this purpose. Management will include the remaining $31,950 in the CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

Development of the proposed Strategic Plan is consistent with direction provided by the Board of Directors at the February 7, 2019, meeting.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Strategic Plan Scope of Work
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

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Scope of Work
CalOptima
Strategic Planning Development

Anticipated Consultant Outcomes
To develop and approve the 2020-2022 Strategic Plan in collaboration with CalOptima Board of Directors, Executive Leadership and Community stakeholders.

The CONTRACTOR shall provide the following tasks and activities. Please note the dates provided are estimated dates and are for planning purposes only.

1. **Project Initiation** — April 2019
   - Define key deliverables
   - Identify key contacts
   - Establish detailed work plan and milestones

2. **Discovery** — May-June 2019
   - Review previous strategic plans
   - Interview CalOptima Board of Directors
   - Interview CalOptima Executive team and other key staff
   - Identify strategic priority areas
   - Identify over-arching themes and outcomes
   - Identify key stakeholders

3. **Planning and Design** — June-July 2019
   - Consolidate feedback received during interview sessions
   - Facilitate planning session with CalOptima Board of Directors
   - Establish stakeholder engagement plan

4. **Stakeholder Engagement** — July-August 2019
   - Engage CalOptima advisory committees
     - Member Advisory Committee
     - Provider Advisory Committee
     - OneCare Connect Member Advisory Committee
     - Whole Child Model Family Advisory Committee
   - Engage and interview other key stakeholders/key informants
   - Consolidate feedback

5. **Strategic Plan Development** — August -September 2019
   - Analyze feedback
   - Develop draft strategic plan

6. **Finalize Strategic Plan** — September-December 2019
   - Finalize draft
   - Review draft with Board of Directors
   - Incorporate feedback
   - Review Final with Board of Directors

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Chapman Consulting	1133 Los Robles St.	Davis	CA	95618
Pacific Health Consulting Group	72 Oak Knoll Ave.	San Anselmo	CA	94960
Curt Pringle & Associates	1801 E. Katella Ave., Suite 1002	Anaheim	CA	92805
Medecision, Inc.	550 E. Swedesford Road, Suite 220	Wayne	PA	19087
Milliman, Inc.	1301 Fifth Ave., Suite 3800	Seattle	WA	98101
Optum	11000 Optum Circle	Eden Prairie	MN	55344
Spring Street Exchange	26 Grant St.	Lexington	MA	02420

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Board of Directors Meeting
November 7, 2019

CalOptima Draft 2020-2022 Strategic Plan

Background
At the February 7, 2019, CalOptima Board of Directors (Board) meeting, staff presented an Information Item on the Year two (2) Progress Report of CalOptima's 2017-2019 Strategic Plan; the current Strategic Plan will expire at the end of the 2019 calendar year. The Information Item also included the planning process for CalOptima's 2020-2022 Strategic Plan. During the April 24, 2019 meeting, the Board approved a contract with Chapman Consulting to provide consulting services related to the CalOptima 2020-2022 Strategic Plan activities.

Discussion
Chapman Consulting performed work to support the development of the 2020-2022 Strategic Plan. Activities included reviewing the current and previous Strategic Plans, conducting Board of Directors and Executive staff interviews, facilitating a full-day Board of Directors planning session and recently also facilitating a joint meeting of CalOptima's Advisory Committees (Member Advisory Committee, OneCare Connect Member Advisory Committee, Whole-Child Model Family Advisory Committee and Provider Advisory Committee), as well as a meeting with Health Network representatives, and developing an Environmental Scan. A draft of the 2020-2022 Strategic Plan and the Environmental Scan are included for review.

Next Steps
Your Board's feedback to the draft, if any, will be incorporated by Chapman Consulting. Staff expects to request approval of the CalOptima 2020-2022 Strategic Plan during the December 2019 Board meeting. The priority areas will support planning and development of programs and initiatives over the course of the next few years. These will include, for example, development of the Expenditure Plan for Intergovernmental Transfer Funds expected during Fiscal Year 2020 and upcoming Quality Initiatives; staff will begin to seek stakeholder input and then return to your Board for approval of the Expenditure Plans, as appropriate.

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CHAPMAN
CONSULTING

DRAFT

CalOptima Strategic Plan 2020-2022

DRAFT DOCUMENT FOR REVIEW

DOCUMENT PENDING GRAPHIC DESIGN

BY:
ATHENA CHAPMAN & CAROLINE DAVIS
OCTOBER 28, 2019

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Message from CEO

CalOptima Staff to Provide

About CalOptima

CalOptima's Mission

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

CalOptima's Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members

Products

Medi-Cal (California's Medicaid Program): For low-income children, adults, seniors and persons with disabilities.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan): For people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits. Also included are benefits for worldwide emergency care, dental care, vision care and fitness benefits. Other benefits are transportation to medical services and a Personal Care Coordinator.

OneCare (HMO SNP): A Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. Benefits are covered in one single plan, making it easier to get health care.

Program of All-Inclusive Care for the Elderly (PACE): A long-term comprehensive health care program that helps older adults remain independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community. PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal.

As of August 30, 2019, CalOptima has over 760,000 enrollees[i]: **(converted to pie chart in final version)**

- Medi-Cal: 746,052
- OneCare Connect (Cal MediConnect): 14,090
- OneCare: 1,545
- PACE: 345

Health Insurance Coverage in Orange County

CalOptima covers over 20% of Orange County residents.[ii]

Current Health Insurance Coverage Type	Orange County
Uninsured	6.7%

Medicare & Medicaid (Dual Eligibles)	3.0%
Medicare	11.2%
Medicaid	19.1%
Employment-based	51.8%
Privately Purchased	7.5%
Other Public Coverage	0.7%

CalOptima Enrollee Profile[iii]

Members by Age (converted to pie chart in final version):

- Age 0-18 40%
- Age 19-64 48%
- Age 65+ 12%

Low Administrative Costs:

CalOptima spends nearly 96 cents of every dollar on member care and only 4 cents on program administration, which reinforces our commitment and mission as a community health plan that provides cost-effective quality health care services in a compassionate manner.

Provider Network Composition:

CalOptima has a strong provider network, which includes the contracted health networks, to serve our members:

- 1,569 primary care providers
- 6,854 specialists
- 40 acute and rehab hospitals
- 33 community health centers
- 571 pharmacies
- 99 long-term care facilities
- 5 PACE alternate care settings

High-Quality Care:

CalOptima offers high-quality care to our members:

- For five years in a row, CalOptima was the top rated Medi-Cal plan in California, according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings (2014-2019).
- For 2019-2020, no other health plan received a higher rating.
- NCQA has awarded an accreditation status of Commendable to CalOptima Medi-Cal.

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Health Care Landscape Review

CalOptima's 2020-2022 Strategic Plan reflects the need to be responsive to a wide variety of federal, state and local priorities, considerations and issues. The landscape review is a summary of highlights from a comprehensive Environmental Scan that was completed to inform the Strategic Plan.

Federal Landscape

At the federal level, the policy landscape has been characterized by uncertainty for the last three years, and this is expected to continue for the foreseeable future. The Centers for Medicare and Medicaid Services (CMS), which provides the federal funding for, and oversight of, California's Medi-Cal program, has established a set of strategic priorities focused on driving innovation, implementing patient-centric approaches, and demonstrating results that improve care and lower costs. CalOptima will look to CMS's goals to prioritize development of innovative approaches that are aligned with the federal government. In addition, federal immigration policy may negatively impact Medi-Cal enrollment.

State Landscape

Within California, the health policy landscape is in transition with the election of Governor Newsom in November 2018. Governor Newsom has an ambitious health care agenda focused on expanding coverage for all Californians and reigning in costs. Within the California Department of Health Care Services (DHCS), key initiatives are underway that will shape the future of the Medi-Cal program, and impact CalOptima's work over the next three years.

Medi-Cal Vision: 2021 and Beyond

The current federal Section 1115 Medicaid waiver, referred to as Medi-Cal 2020, expires at the end of 2020. As part of renewing the waiver, DHCS is launching a major restructuring of Medi-Cal, known as California Advancing and Innovating Medi-Cal (CalAIM), which is designed to reduce the complexity of the program, focus on population health and increase the use of value-based purchasing strategies. CalOptima will contribute to the CalAIM discussions and, ultimately, to the implementation of Medi-Cal's next chapter.

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- Following the Strategic Planning Session, we held a joint meeting of all the Advisory Committees to solicit their input on the strategic priorities. We also convened Health Network representatives to gather their input on the next strategic plan.
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Strategic Priorities & Objectives

Our members are the essential focus of the Priorities and Objectives for the 2020-2022 Strategic Plan and are supported by the programs and services provided by CalOptima.

Innovate & Be Proactive

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- Identify and Collaborate on Local Priorities and Needs
- Leverage New Federal and State Programs and Services to Improve Access and Quality of Care for Members
- Seek Opportunities to Further Integrate Care for Members

Expand CalOptima's Member-Centric Focus

- Focus on Population Health
- Strengthen Provider Network and Access to Care
- Enhance Member Experience and Customer Service

Strengthen Community Partnerships

- Increase Collaboration with Providers and Community Stakeholders to Improve Care
- Utilize Strong Advisory Committee Participation to Inform Additional Community Engagement Strategies

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- Evaluate and Implement Value-Based Purchasing Strategies that Drive Quality
- Deploy Innovative Delivery Models to Address Social Determinants of Health and Homelessness
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Enhance Operational Excellence and Efficiency

- Maintain Strong Culture of Compliance
- Preserve CalOptima's Financial Stability
- Invest in Infrastructure and Efficient Processes
- Engage Workforce and Identify Development Opportunities

[i] Source: CalOptima Fast Facts, Available at: https://www.caloptima.org/en/About/AboutCalOptima/FastFacts.aspx

[ii] Source: CHIS, 2017 California Health Interview Survey data. Available at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

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[iii] Source: CalOptima Fast Facts, Available at:
https://www.caloptima.org/en/About/AboutCalOptima/FastFacts.aspx

DRAFT

CHAPMAN
CONSULTING

CALOPTIMA 2020-2022 STRATEGIC PLAN

ENVIRONMENTAL SCAN

BY:
ATHENA CHAPMAN & CAROLINE DAVIS
SEPTEMBER 19, 2019

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Introduction

CalOptima's mission is "to provide members with access to quality health care services delivered in a cost-effective and compassionate manner," and the health plan's vision is "to be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes" for its members. The environment in which the health plan realizes its mission and vision is complex, reflecting the intersection of federal- and state-level priorities with local needs and goals. This memo provides an overview of the federal, state and local landscape that set the stage for the opportunities for and challenges to CalOptima's work and how that interacts with its daily operations and longer-term strategic vision.

The information from the environmental scan has been integrated with the themes and insights obtained from the interviews with CalOptima's Board of Directors, Executive Team, and Advisory Committee provides the framework for the 2020-2022 CalOptima Strategic Plan. The data in the environmental scan is as of July 2019.

CalOptima

In 1993, the Orange County Board of Supervisors created CalOptima as a County Organized Health System (COHS). Initially created to serve the Medi-Cal program, CalOptima currently offers the following four programs:

- Medi-Cal – a public-sector health insurance program that serves low-income individuals and families
- OneCare Connect (Cal MediConnect Plan) – a program that serves members eligible for both Medi-Cal and Medicare coverage (i.e., the dual-eligible population). This program combines the Medicare and Medi-Cal benefits into a single plan and offers additional benefits as well.
- OneCare – a Medicare Dual Special Needs Plan (D-SNP) for individuals who qualify for both Medicare and Medi-Cal.
- Program for All-Inclusive Care for the Elderly (PACE) – a community-based program that supports frail seniors by providing coordinated and integrated services to help them continue to live independently. PACE provides the acute and long-term care services covered by both Medicare and Medi-Cal.

As of July 2019, CalOptima has over 750,000 enrollees across the following products:

- Medi-Cal: 739,771
- OneCare Connect (Cal MediConnect): 14,257
- OneCare:1,530
- PACE: 335[i]

As a COHS plan, CalOptima is the sole Medi-Cal managed care plan in Orange County, which makes it an integral part of the safety-net. CalOptima has demonstrated it can take advantage of its unique role and have a direct impact on care delivery, cost, and quality for this population. For the five years in a row, CalOptima received recognition as the top-rated health plan in California for outstanding quality, according to the National Committee for Quality Assurance (NCQA); For 2019-2020, no other health plan

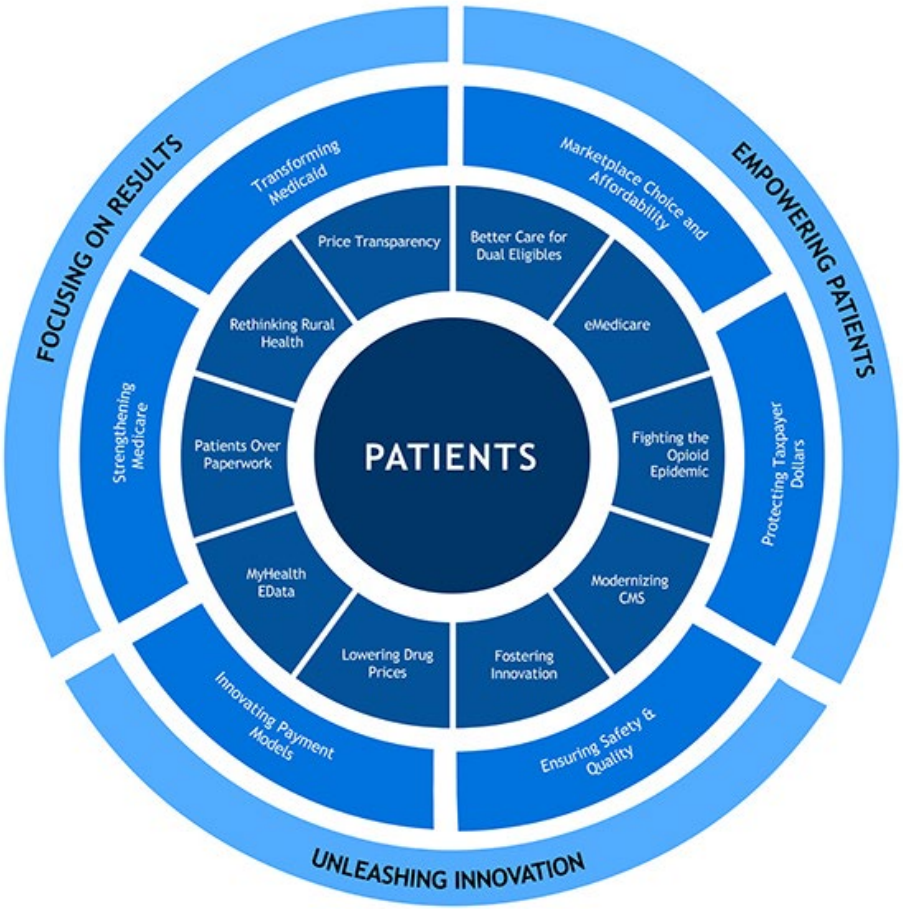
received a higher rating. CalOptima's NCQA accreditation was recently renewed at the Commendable level again.

Additionally, CalOptima has continued to explore additional lines of business and pilot programs that are in line with the needs of its community and to test new ways to deliver high-quality care for its members. CalOptima is in a strong strategic position to build on its successes and continue to explore additional ways to support its membership and local community.

Federal Landscape

For the last several years, the federal health policy landscape has been defined by uncertainty, and this will continue into the foreseeable future. This debate could be restarted depending on the outcomes of the 2020 election. Further, lawsuits seeking to repeal the ACA continue to work their way through the federal court system. The growth in the federal deficit also increases the likelihood of Congressional action to reduce Medicaid and Medicare spending, which could include converting Medicaid financing into a block grant or per capita cap structure.

The Centers for Medicare and Medicaid Services (CMS), which provides the federal funding and oversight for the Medicaid program, has established 16 strategic initiatives, which are shown below.[ii]



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CMS' strategic priorities are focused on driving innovation, implementing patient-centric approaches, and demonstrating results that improve care and lower costs. These priorities can be used to help guide how CalOptima can strategically position itself and prepare to proactively work toward CMS's goals as well as provide insights into potential areas of focus at the federal level for both Medicaid and Medicare. The ability to anticipate changes at the federal level and minimize the disruption caused by the implementation of new federal requirements and initiatives will allow CalOptima to be proactive and innovative.

In separate but relevant activity, the federal Administration's recent actions related to public programs may have a negative impact on total Medicaid enrollment. A recent fact sheet from the Kaiser Family Foundation notes concerns about current immigration policy and the impacts on enrollment in public sector programs (including Medicaid) by lawfully present immigrants, citizen children immigrants, and undocumented populations.[iii] The recently-published "public charge" rule also is likely to lead to a decline in Medicaid enrollment as it expands the programs used to deem a legal immigrant a "public charge" (which can make it more difficult for an individual to gain legal permanent residency status or obtain a visa to enter the U.S.) to include Medicaid. [iv] It is expected the public charge rule will be challenged in court, but the Medicaid enrollment impacts in California may be felt more immediately than this issue can be resolved.

State Landscape

Within California, the health policy landscape is in transition with the election of Governor Newsom in November 2018. The appointment of a consumer-focused and innovative health policy team demonstrates that the Governor intends to continue to drive significant changes across the health care landscape in California. Newsom has an ambitious health care agenda that includes moving California to some form of universal coverage. Additionally, the Newsom Administration has used its healthcare platform to take several significant actions in its first six months:

- Appointment of Nadine Burke Harris, MD as the first Surgeon General for California. Surgeon General Dr. Burke Harris has a strong focus on how Adverse Childhood Experiences (ACES) and social determinants of health impact health outcomes;
- Appointment of Tom Insel as the first state Mental Health Czar with a directive to develop a blueprint to address behavioral health issues across the state;
- Release of an Executive Order on bulk pharmacy purchasing to reduce rising prescription drug costs, including the carve-out of pharmacy from the Medi-Cal managed care plans;
- Release of an Executive Order that calls for the development of a "Master Plan for Aging" by October 2020 with input from a Cabinet-Level Workgroup that will work with a Stakeholder Advisory Committee comprised of a diverse set of stakeholders with both a research and long-term care subcommittee structure;
- Establishment of the Healthy California for All Commission to develop a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system for all Californians.
- Enactment of a provision to expand full scope Medi-Cal coverage for undocumented adults up to age 26 using state General Funds to cover the costs of enrollment and coverage;

- Enactment of a California-specific individual mandate penalty and increased subsidies for individuals and families above the ACA amounts to provide stability in the individual insurance market and increase coverage for individuals with incomes above the Medi-Cal eligibility requirements; and

Implementation of the Governor's health policy agenda is the responsibility of the Secretary of the California Health & Human Services (CHHS) Agency, Mark Ghaly, MD. The Secretary oversees 15 Departments, including the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). While CalOptima works closely with DHCS, it is important to understand the larger health care context in California as the state continues to move towards additional integration across public programs to address social determinants of health and complex issues such as homelessness. This will require collaboration with multiple state-level departments which will impact CalOptima's work.

CHHS' current guiding principles include the following:

1. Adopt a culture of collaboration and innovation;
2. Focus on outcomes & value generation;
3. Use data to drive action;
4. Put the person back in person-centered; and
5. See the whole person. [v]

These principles will guide DHCS's work, and CalOptima can use it to help think proactively and strategically about likely actions that will be taken over the next several years. Some initiatives are starting to take shape at DHCS and should be factored into CalOptima's next strategic plan to ensure necessary resources will be available and that the health plan can be as proactive in its preparations as possible. While DHCS does not have a current strategic plan,[vi] the Department has shared priorities that are in-line with the CHHS vision to provide a better patient experience with improved outcomes and lower costs.

The following graphic, which may be updated in the next strategic plan, defines the high-level goals of DHCS. [vii] This highlights many of the same themes outlined by CHHS and CMS, including the focus on the member, providing high-quality care, and using public dollars in an effective and efficient manner.



With the rapid growth of the program due to the addition of the Medi-Cal expansion population in 2014, Medi-Cal is the largest Medicaid program in the nation, providing coverage to one-third of all Californians. In more recent years, Medi-Cal enrollment growth has leveled off (and even declined slightly), but the 2019-2020 Budget provision extending Medi-Cal eligibility to undocumented immigrants between the ages of 19-25 is projected to provide full-scope Medi-Cal coverage to an additional 138,000 individuals when it takes effect in 2020.[viii] As discussed above, however, it is possible enrollment will be lower than anticipated due to federal immigration policy.

Currently, DHCS is engaged in several initiatives and pilots that point to its direction to increase person-centered care and to integrate across programs. These include the Coordinated Care Initiative, Whole-Person Care Pilots, Health Homes, and the Whole-Child Model. CalOptima is currently involved with all these initiatives at some level and has demonstrated a commitment to being innovative and testing new programs that meet the strategic priorities of the state. As these pilots and programs are evaluated and DHCS determines how it will incorporate lessons learned into the broader Medi-Cal program, it is

inevitable there will be some expansion of the programs and some adjustments for the pieces that did not yield expected results. CalOptima is in a strong position to move forward with the state as these projects evolve and to provide input and feedback to DHCS to drive sustainable changes to the Medi-Cal program.

Key Medi-Cal initiatives underway at DHCS that will shape the future direction of the program, and impact CalOptima's work, are discussed below.

Expiration of Federal Section 1115 Medicaid Waiver (Medi-Cal 2020)

The current federal Section 1115 Medicaid waiver expires at the end of 2020. Currently, the entire managed care program (including the authority under which CalOptima operates) is included in the Section 1115 waiver. In addition, the waiver includes authorization for the Whole Person Care Pilots (WPCP), Public Hospital Redesign & Incentives in Medi-Cal (PRIME), the Global Payment Program, Dental Transformation Initiatives, the Drug Medi-Cal Organized Delivery System, California Children's Services (CCS) pilots, and the Coordinated Care Initiative (CCI). The federal government has changed its guidance to states regarding the calculation of "budget neutrality" (all Section 1115 waivers are required to demonstrate they do not cost the federal government more than would otherwise have been spent in the absence of the waiver), which will result in less federal funding for California under a new waiver. This shortfall will drastically reduce the amount of funding available for DHCS to invest in pilot programs and initiatives and will require the transition of many of the activities under the current waiver into sustainable models, which may involve moving those components into the managed care program. The theme of consolidation, alignment, and standardization across the Medi-Cal program is expected to be a significant part of the waiver renewal and is reflected in other activities by DHCS as outlined below. However, because many of these pilot programs, such as the WPCP, vary significantly in design and target populations by county, standardization will present unique challenges for each county, and DHCS will have to identify the components that will be included statewide.

DHCS California Advancing and Innovating Medi-Cal (CalAIM) Initiative

In 2018, DHCS convened a comprehensive set of stakeholders for its Care Coordination Assessment Project to discuss how to improve Medi-Cal care coordination and developed key themes and next steps that emerged from these meetings. [ix] Key finding included the desire to standardize benefits across counties, streamline assessments across programs, and reduce the number of carve-out benefits (such as specialty mental health, dental, and long-term care). DHCS has used the recommendations from the Care Coordination Assessment Project to develop its next set of policy initiatives and program changes, including the newly announced CalAIM initiative. CalAIM is a multi-year initiative with the following objectives: "(1) reducing variation and complexity across the delivery system; (2) identifying and managing member risk and need through population health management strategies; and (3) improving quality outcomes and driving delivery system transformation through value-based initiatives and payment reform."[x]

Throughout 2019 and 2020, DHCS intends to engage stakeholders to discuss both CalAIM and the renewal of Medi-Cal's federal waivers. DHCS has indicated it will transition all existing managed care authorities into a single, consolidated 1915(b) waiver that will include the Medi-Cal Managed Care Plans, the County Mental Health Plans, the Drug-Medi-Cal Organized Delivery System Plans, and the Dental Managed Care Plans. While DHCS has yet to release a detailed CalAIM proposal, they have shared some

limited information about the stakeholder workgroups that will be formed to provide input on the development of CalAIM.[xi] Workgroup topics include: (1) Population Health Management and Annual Health Plan Open Enrollment; (2) NCQA Accreditation; (3) Enhanced Cared Management and In-Lieu-of-Services; (4) Behavioral Health; and (5) Full Integration Pilots.

DHCS Stakeholder Advisory Committee

The DHCS Stakeholder Advisory Committee (SAC) was originally established to provide input on the development of the federal Section 1115 waiver. However, it has evolved over time to become the body DHCS uses to discuss issues well beyond the federal waiver, including health care reform and state developments more broadly. With the upcoming renewal of the Section 1115 waiver, DHCS has stated it will begin to discuss the specific proposals related to transitioning the Medi-Cal 2020 waiver into a sustainable model in October 2019.

DHCS Behavioral Health Stakeholder Advisory Committee

The Behavioral Health Stakeholder Advisory Committee (BH-SAC) is a newly formed, stakeholder workgroup focused on the issues related to the delivery of behavioral health services in Medi-Cal. The current system, which is bifurcated between the health plans (which are responsible for delivering mild-to-moderate services) and the counties (which are responsible for specialty mental health services), is under scrutiny and criticism from many stakeholders. DHCS recently received federal approval to extend the current federal Section 1915(b) Specialty Mental Health Services waiver to the end of 2020 to align with renewal of the Section 1115 waiver. As noted above, DHCS intends to submit a single consolidated federal Section 1915(b) waiver that will include all of the managed care programs across Medi-Cal, including specialty mental health services.

Prescription Drugs Executive Order

On his first day in office, Governor Newsom announced an Executive Order (E.O.) intended to control rising pharmacy costs.[xii] The E.O. includes a shift to bulk purchasing for all government programs, including Medi-Cal (the largest purchaser of prescription drugs in the state). This will involve carving-out the Medi-Cal pharmacy benefit from the health plans, so the state can negotiate for all its programs collectively, which it anticipates will result in lower costs. Even with concerns from Medi-Cal stakeholders and opposition from health plans, DHCS has been instructed to move forward on a very aggressive timeline and complete the transition by January 2021. DHCS recently released an RFP to select a single vendor to manage the entire pharmacy benefit under a fee-for-service arrangement.[xiii] Despite running counter to other actions designed to integrate services and benefits across the Medi-Cal program, it appears pharmacy will be carved-out. Once the shift occurs, the Medi-Cal health plans will need to be prepared to work with the state's pharmacy vendor to access pharmacy data for their members and coordinate care.

DHCS Managed Care Accountability Set

In early 2019, DHCS announced a major change in quality reporting requirements for the Medi-Cal health plans: health plans must report on the complete CMS Core Measures Set for both adults and children (known as the Managed Care Accountability Set in California). [xiv] This represents a significant increase in the number of measures reported and is being implemented for Measurement Year 2019. Additionally, DHCS currently requires that health plans meet a Minimum Performance Level (MPL) of 25

percent and will move to a 50 percent MPL effective for the 2019 Measurement Year. While negotiations between the health plans and DHCS have helped reduce the administrative burden and potential for sanctions in the first year of the transition, this is a heavy lift for the health plans and DHCS, and another indicator of a new Administration that is determined to make changes and maintain aggressive implementation timelines. With themes of quality and value throughout both the federal and state priorities, it is likely the pressure to demonstrate high-value care will continue to be a growing focus of DHCS.

Future of the Coordinated Care Initiative

The Coordinated Care Initiative (CCI), which is currently operating in seven counties, includes the mandatory enrollment of dual eligibles into Medi-Cal Managed Care, implementation of a managed long-term services and supports (MLTSS) benefit, and assumption of risk by the health plans for long-term care placements. [xv] It also includes the Cal MediConnect (CMC) duals demonstration, which has been extended through 2022.[xvi] The CCI has been placed into state law with no sunset date and an expansion of certain elements would be in line with other efforts by DHCS to align and integrate benefits statewide. Notably, DHCS recently announced that, starting in January 2021 (which aligns with the waiver renewal timeline), it will carve-in long-term care benefits to all its managed care models, signaling the move towards standardization of benefits across the state.

The CCI program requires federal waiver authority, and the CMC program requires continued federal approval and negotiation of a three-way contract between DHCS, CMS, and the health plans. The future and status of this program is less certain and may be resolved as part of the Section 1115 waiver discussions and negotiations.

Medi-Cal Managed Care Rates

DHCS must submit actuarially-sound managed care rates to CMS for review and approval. The capitation rates paid to health plans are tied directly to the Medi-Cal benefits included in the health plan contracts. Per federal regulations 42 CFR Section 438.4 (a) defines actuarially sound capitation rates as *"projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO…for the time period and the population covered under the terms of the contract."* Meaning that Medi-Cal Managed Care Plan capitation rates only reflect the costs of providing services and populations included in the contract with DHCS.

The complicated rates structure, which has evolved over many years, has led to thousands of individual rate cells that have to be calculated by DHCS every year. DHCS has been moving to speed up its rate development process, which is currently under almost a two-year delay, to provide more timely rates to health plans and to meet CMS requirements for prospective rate setting. In addition, DHCS has recently indicated it is examining how to move to a regional rate-setting model, which would streamline their work and require significantly fewer rate cells. However, many factors will continue to complicate the rate development process, some of which are outside of DHCS' control. These include directed payments to certain providers, retroactive implementation of benefits, delays in CMS review and approval, and other legislative and administrative activities that impact the Medi-Cal program. As DHCS moves to increase value-based payments and streamline the rate setting process, providing quality data that reflects the cost of providing high-value care will become even more important. Health plans will

want to provide input on these transitions to identify downstream and unintended negative consequences and to promote the timely payment of rates.

Encounter Data Reporting

DHCS has continued to put significant pressure on the health plans to provide complete, accurate, and timely encounter data. Under federal Medicaid regulations, CMS can withhold federal funds if the state does not submit this data as required. Additionally, the Department of Managed Health Care (DMHC) has initiated an encounter data taskforce that is charged with working to standardize and improve encounter data reporting across all health plans (Medi-Cal, Commercial, Medicare, etc.). CalOptima will need to be prepared to respond to any future actions that the state takes as it works to enhance encounter data reporting, which is used for both utilization oversight and rate setting purposes. CalOptima should proactively identify where it can improve encounter data collection and be prepared to work collaboratively with its networks and DHCS.

County Landscape

CalOptima is an integral part of the business community and the health care sector in Orange County. It is important to understand how the federal and state priorities intersect with the local landscape and the needs of the community.

Health Insurance Coverage in Orange County

As shown in the table below, Orange County has over 30 percent of its population enrolled in public programs, which includes Medicare and Medi-Cal, in 2017. [xvii] As the sole Medi-Cal plan in the County, CalOptima has a unique position to impact care delivery and examine ways to reach the additional uninsured. For example, CalOptima offers several plans for individuals with both Medicare and Medi-Cal. Its PACE programs for frail seniors has experienced successful growth, in part due to its implementation of the alternative care setting model allowing members to receive services at local Community-Based Adult Services locations. It's OneCare Connect (Cal MediConnect Plan), on the other hand has experienced enrollment and financial performance challenges; the future of this program is uncertain as CMS has approved extension of this program through 2022.

Current Health Insurance Coverage Type	Statewide	Orange County
Uninsured	7.3%	6.7%
Medicare & Medicaid (Dual Eligibles)	4.3%	3.0%
Medicare	10.9%	11.2%
Medicaid	25.0%	19.1%
Employment-based	44.4%	51.8%
Privately Purchased	6.5%	7.5%
Other Public	1.5%	0.7%

Competitive Orange County Labor Market

According to the 2019 Orange County Community Indicators Report, the cost-of-living in Orange County is 91 percent higher than the national average, and among the highest in California. The high cost-of-living is driven largely by high housing costs. In addition, Orange County's unemployment rate (3.0 percent as of June 2019) continues its six-year trend of outperforming state and national unemployment rates (4.2 percent and 3.8 percent respectively).[xviii] The high cost-of-living coupled with a low unemployment rate are both challenges for CalOptima. As a public plan, CalOptima has difficulty competing with the private sector for staff in terms of salary. In addition, the low unemployment rate in the County means the hiring environment is very competitive.

Community Collaboration

Community Engagement

CalOptima believes in strengthening its partnerships by enhancing communications with local community organizations and supporting these important partners serving CalOptima's members' health care needs. For fiscal year (FY) 2018-2019, CalOptima participated in 126 community events to engage members and the public about CalOptima and its programs, health care and support services. Additionally, CalOptima hosts the quarterly Community Alliances Forum, which is designed to keep CalOptima connected to the health plan's community stakeholders. CalOptima also participates in more than 30 collaborative meetings throughout Orange County. Finally, CalOptima understands the importance of keeping the local community informed about health plan activities. Through their monthly community announcements and quarterly e-newsletter (known as "Community Connections"), the CalOptima provides updates on initiatives and shares information about events and training with more than 2,500 individuals and organizations.

System of Care Data Integration

The County of Orange has launched integrated data initiative for the County's System of Care for individuals experiencing homelessness. When complete, this initiative will support information sharing across county agencies touching county residents for services such as health care, law enforcement, court system, social services and other community resources. Shared data will enhance the coordination of services for "high utilizers" of the County's System of Care and may provide earlier opportunities for early intervention before residents become high utilizers. CalOptima will explore opportunities for data exchange to benefit the mutual individuals we serve.

Behavioral Health/Be Well OC

In 2018, local public and private stakeholders came together to work on behavioral health issues. In addition to CalOptima, key participants include the County Board of Supervisors, Providence St. Joseph Health, and Kaiser Permanente. Under this initiative, a regional wellness center is envisioned in Orange County to serve individuals with mental health needs regardless of payor source. The Be Well OC initiative integrates across silos to address social determinants of health and recognizes issues related to the justice system and housing have a significant impact on health and must be considered as part of comprehensive solution. This mirrors concerns, and priorities highlighted by the state and federal

government. CalOptima is well positioned to leverage this local experience to demonstrate its commitment to population health management and effective delivery system transformation.

Homelessness

In Orange County, as across the state, the homeless population has increased significantly over the past few years because of increased housing costs and stagnant wages. To address this problem Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health, health care, housing, community corrections, housing, benefits and support services.[xix] The county's WPCP is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care – As part of the Whole Person Care program, services provide post-acute care for update to 90-day stay for homeless CalOptima Members.
- Medical Respite Care – As an extension to recuperative care program, CalOptima provides additional respite care beyond 90 days of recuperative care under the Whole Person Care program.
- Clinic Field Teams – In collaboration with Federally Qualified Community Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, the pilot program provides immediate acute treatment/urgent care to homeless CalOptima Members.
- Homeless Clinic Access Program – The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventative care services at Orange County shelters.
- Hospital Discharge Process for Members Experiencing Homelessness – Support is designed to assist hospitals with the increased cost associated with discharge planning under the new State Legislative requirements.

As noted above, addressing homelessness is one of the Governor's priorities, and CalOptima can expect the state will be looking for innovative partners to address this public health crisis.

Health Homes Program (HHP)

As was noted above, one of the initiatives DHCS has implemented to increase person-centered care and to integrate across programs is HHP. CalOptima has elected to bring this program to Orange County to provide increased coordinates care for its highest risk Medi-Cal members. Eligible members choosing to participate and will receive high touch services, such as in-person health needs assessment, accompaniment to key medical appointments and housing navigation and sustainability services.

Whole Person Care Pilot Transition to CalOptima

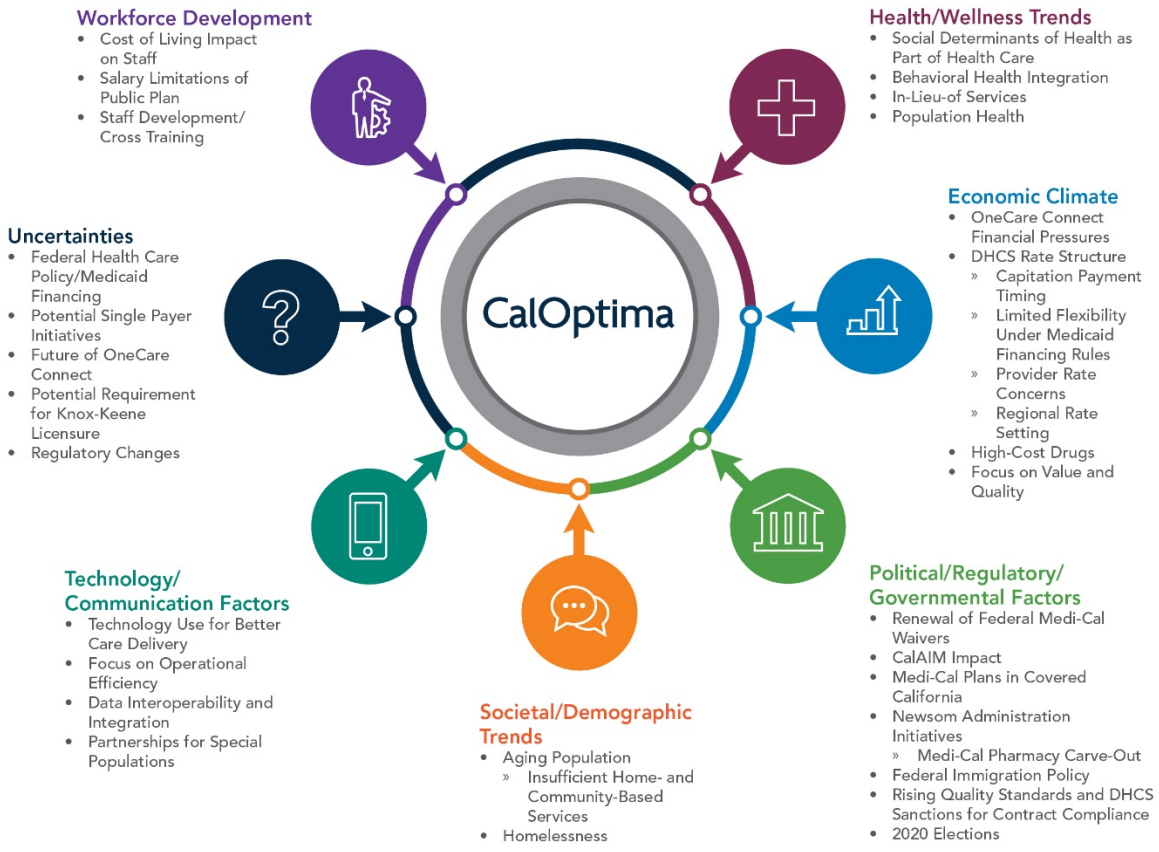
As was noted above, the WPCP are expected to transition to the Medi-Cal managed care plans when the waiver expires at the end of 2020. Orange County's Health Care Agency is the lead entity for the WPCP, and CalOptima has a limited role to provide personal care coordination services and access to covered Medi-Cal benefits. Because details are limited at this time, and it is unclear how DHCS may restructure

the individual WPCPs as they transition into managed care, CalOptima will have to be prepared to work collaboratively with the WPCP stakeholders once DHCS releases more detailed guidance and timeframes. HHP implementation will provide a foundation for this transition.

CalOptima Health Networks and Access

Across California, there are concerns about access to care, rising cost of living, and a lack of physicians and other health workers. These issues are particularly acute in the Medi-Cal program, which recently launched a physician loan forgiveness program to encourage new physicians to serve this population. CalOptima is engaged in an assessment of its health network structure and reimbursement arrangements to develop stronger networks with value-based payment arrangements. The Delivery System Study, being conducted by Pacific Health Consulting Group, is expected to be finalized in early 2020 and will present options for CalOptima and its contracted health networks to consider. It is increasingly challenging to recruit and maintain providers with the low reimbursement rates and significant administrative workload associated with the Medi-Cal program (e.g., all providers must now enroll with DHCS). Continued investment in its health networks and collaboration with providers will allow CalOptima to continue to be innovative and meet the needs of all its members.

Environmental Considerations



[i] https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/NewsandPublications/2019/2019-09_FastFacts_508.ashx

[ii] Source: https://www.cms.gov/about-cms/story-page/our-16-strategic-initiatives.html

[iii] Kaiser Family Foundation Fact Sheet, "Changes to 'Public Charge' Inadmissibility Rule: Implications for Health and Health Coverage," August 2019 Update. Available at: http://files.kff.org/attachment/Fact-Sheet-Changes-to-Public-Charge-Inadmissibility-Rule-Implications-for-Health-and-Health-Coverage

[iv] https://www.uscis.gov/legal-resources/final-rule-public-charge-ground-inadmissibility

[v] https://www.chhs.ca.gov/wp-content/uploads/2019/07/CHHSA-Guiding-Principles.pdf

[vi] The most recent DHCS strategic plan expired in 2018. Available at: https://www.dhcs.ca.gov/Documents/StrategicPlan/DHCS%20Strategic%20Plan%209-14-15.pdf

[vii] https://www.dhcs.ca.gov/Documents/StrategicPlan/DHCS%20Strategic%20Plan%209-14-15.pdf

[viii] http://www.ebudget.ca.gov/2019-20/pdf/BudgetSummary/FullBudgetSummary.pdf

[ix] https://www.dhcs.ca.gov/services/Pages/Care-Coordination-Assessment-Project.aspx
[x] https://www.dhcs.ca.gov/calaim
[xi] https://www.dhcs.ca.gov/calaim
[xii] https://www.gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf
[xiii] https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/CSBmcrxHome.aspx
[xiv] https://www.dhcs.ca.gov/dataandstats/Pages/Core-Set-Measures-Reporting.aspx
[xv] https://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareInitiative.aspx
[xvi] http://calduals.org/
[xvii] Source: CHIS, 2017 California Health Interview Survey data. Available at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

[xviii] Orange County 2019 Community Indicators Report. Available at: https://www.ocbc.org/wp-content/uploads/2019/09/CommIndicators_Report_091219-WEB.pdf
[xix] http://ochmis.org/wp-content/uploads/2019/08/2019-PIT-FINAL-REPORT-7.30.2019.pdf

Continued to a Future Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

16. Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

1. Ratify amendments to the Medi-Cal health network contracts, except AltaMed Health Services Corporation, to include payment by CalOptima of startup costs associated with the Whole-Child Model program; and,
2. Ratify the expenditure of up to $1.75 million in IGT 6 and 7 funds for implementation.

Background

The California Children's Services Program (CCS) is a statewide program, providing medical care, case management, physical/occupational therapy, and financial assistance for children up to age 21 meeting financial and health condition eligibility criteria. Following the approval of Senate Bill 586 in September 2016, the Department of Healthcare Services (DHCS) was given the authority to incorporate a number of CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS), referred to as the Whole Child Model (WCM). CalOptima began the process of transitioning its Medi-Cal Health Networks in June 2018, with implementation going live as of July 1, 2019. The importance of a successful WCM transition cannot be overstated, as it directly impacts the wellbeing of CalOptima's most at-risk pediatric members.

IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 6 and 7 funds were received in May 2018 from the Department of Health Care Services (DHCS) totaled $31.1 million. After initial disbursements of $10 million for the Homeless Health Initiative, the Board authorized the remaining balance of $21.1 million to be used for community grants, internal initiatives and program administration. On August 1, 2019, the Board authorized $1.75 million for the Whole Child Model Assistance for Implementation and Development (WCM AID), which was approved as an internal initiative. The funds were designated to aid health networks in developing and implementing a successful delivery system for the WCM program.

Discussion

Health networks were required to cover a portion of the WCM program's startup expenses incurred before the launch on July 1, 2019. Following the Board's August 1, 2019 approval of the IGT 6 and 7 allocation for WCM startup costs, health networks were notified that they would receive a one-time, fixed payment of $50,000, plus applicable variable costs up to the amount allowed per network based on the number of WCM assigned members. CalOptima provided criteria for reimbursement, including

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receipt of attestations demonstrating that the costs were incurred prior to the WCM program go-live date of July 1, 2019, and that expenditures fall within the specified categories of:

- Staffing, recruitment and training.
- Systems and infrastructure.
- Other expenses such as educational materials, notices, etc.

Staff seeks authority to ratify contract amendments and expenditures for the Medi-Cal health networks, except AltaMed Health Services Corporation, to aid with start-up costs and implementation of the WCM program.

Fiscal Impact

The recommended action to amend Medi-Cal health network contracts to include disbursement of IGT 6 and 7 funds for WCM Assistance for Implementation and Development has no fiscal impact to CalOptima's operating budget. The Board authorized the allocation of $1.75 million from IGT 6 and 7 funds for this purpose at the August 1, 2019, meeting. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

The recommended action ensures CalOptima's Medi-Cal health network contracts are updated to reflect receipt of IGT 6 and 7 funds for reimbursement of startup costs associated with the WCM program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 3, 2017; Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot
3. Previous Board Action dated August 1, 2019; Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

/s/ Michael Schrader — *11/26/2019*
Authorized Signature — **Date**

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Continued to a Future Board Meeting

Attachment to December 5, 2019 Board of Directors Meeting – Agenda Item 16

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Health Network	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CalOptima Community Network	505 City Parkway West	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Ave, #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suit #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
14. Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

Contact
Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions
1. Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1 million for community grants and internal projects; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into grant contracts with the recommended community grantees.

Background
Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1 – 7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On August 3, 2017, CalOptima's Board of Directors approved the recommendation to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

Subsequently, CalOptima released Requests for Information/Letters of Interest (RFI/LOI) from organizations to help determine funding allocation amounts for the priority areas and received 117 responses. Initial projections of available IGT 6/7 funds were estimated to be $22.1 million.

In May 2018, CalOptima received final IGT 6 and 7 funding from the Department of Health Care Services (DHCS), resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. On August 2, 2018, the Board approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program. On September 6, 2018 the Board authorized the remaining available balance of $21.1 million to be used for community grants, internal initiatives and program administration.

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Subsequently, at its February 22, 2019 Special Meeting, the Board approved funds to be reallocated to the Clinical Field Teams Pilot for the Homeless Health Initiatives. The funds were reallocated from Requests for Proposals (RFP) 4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) in the total amount of $1 million which were not recommended for grants. In addition, $100,000 IGT 6 funds previously approved by the Board were reallocated from Internal Initiatives to the Clinical Field Teams Pilot. The reallocations were ratified at the April 4, 2019 Board meeting.

Proposed Allocation for community grants and internal initiatives is as follows:

Community Grants

Request for Proposal	Priority Area	Allocation Amount
1. Access to Outpatient Mental Health Services	Children's Mental Health	$4,850,000
2. Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	$4,850,000
3. Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000
4. Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
5. Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA	$1,000,000
6. Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
TOTAL		**$16,700,000**

Internal Initiatives

Internal Project Examples: - IS and other infrastructure projects as summarized below.	$2,400,000
TOTAL	**$2,400,000**

External subject matter experts and staff performed an examination of the RFP responses and evaluated them based on the following criteria:

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- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do and Director DiLuigi, met to discuss the results of the 54 RFP responses for the Children's Mental Health and Opioid and Other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the evaluation committees results and RFP recommendations, the Ad Hoc committee is recommending the following allocation of approximately $16.7 million for IGT 6 and 7 Board-approved priority areas through four (4) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	Children's Bureau of Southern California	$3,390,000
	OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$685,000
	Boys & Girls Clubs of Garden Grove	$325,000
	Jamboree Housing	$450,000
RFP 2. Integrate Children's Mental Health Services into Primary Care ($4.85 million)	CHOC Children's	$4,250,000
	Friends of Family Health Center	$600,000
RFP 3. Increase Access to Medication-Assisted Treatment ($6 million)	Coalition of Orange County Community Health Center	$6,000,000
RFP 5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	Serve the People	$1,000,000
TOTAL		**$16,700,000**

As noted above, the ad hoc is not recommending grants for two of the RFP categories (4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) and the associated funding was previously reallocated to the Clinical Field Teams Pilot at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

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Internal Initiatives
In addition, staff reviewed four internal applications and is recommending an allocation of $2.4 million for internal projects. Funding of $100,000 from the Internal Initiatives budget was reallocated to the Clinical Field Team pilot for the Homeless Health Initiatives at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Project	Amount
Whole Child Model Assistance for Implementation and Development (WCM AID)	$1,750,000
Master Electronic Health Record (EHR) System	$650,000
TOTAL	**$2,400,000**

Fiscal Impact
The recommended action to approve the allocation of $19.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, will work with our provider and community partners to address the health care needs of the members we serve.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: IGT 6 and 7 Expenditure Plan Allocation
2. CalOptima Board Action dated August 3, 2017, Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7
3. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Fund
4. CalOptima Board Action dated September 6, 2018, Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants
5. CalOptima Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but no limited to, Funding and Provider Contracting
6. IGT 6/7 RFP Responses

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

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IGT 6 and 7 Community Grant Award Recommendations

August 1, 2019

Candice Gomez
Executive Director, Program Implementation

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Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
  - IGTs 8–9: Funds must be used for Medi-Cal covered services for the Medi-Cal population
- CalOptima Board of Directors approved IGT 6 and 7 priority areas for community-based funding opportunities
  - Children's Mental Health
  - Homeless Health
  - Opioid and Other Substance Overuse
  - Other Needs Identified by the Member Health Needs Assessment

Background (cont.)

- Received 117 RFIs to identify strategies for each priority area
- IGT 6 and 7 funds of $31.1 million were received in May 2018
  - $10 million approved for recuperative care services in August 2018
  - $21.1 million allocated for community grants, internal initiatives and program administration in September 2018
    - $17.7 million in community grants
    - $2.5 million in internal initiatives
    - $900,000 in program administration (over 3 years)
- Released RFPs, evaluated responses and conducted site visits from September 2018–January 2019

RFP Evaluation Criteria

- Organizational capacity and financial condition
- Statement of need that describes the specific issue or problem and the proposed program/solution
- Impact on CalOptima members with outreach and education strategies
- Efficient and effective use of potential grant funds for proposed program/solution

Site Visits

- Subject matter experts and staff conducted site visits to finalist organizations
- Questions were asked to:
  - Better understand the organization, current services provided and the proposed project
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
  - Determine if there are any concerns with awarding a grant to the organization

RFP Summary

RFP	Total Received	Total Recommended
1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	26	4
2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)	10	2
3. Increase Access to Medication-Assisted Treatment ($6 million)	10	1
4. Expand Mobile Food Distribution Services ($500,000)	1	0
5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	5	1
6. Expand Access to Food Distribution Services for Older Adults ($500,000)	2	0
Total	**54**	**8**

1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Children's Bureau of Southern California	$3,500,000	$3,390,000
2	OCAPICA (Orange County Asian & Pacific Islander Community Alliance Inc.)	$685,000	$685,000
3	Boys & Girls Club of Garden Grove	$325,200	$325,000
4	Jamboree Housing	$692,000	$450,000
	Total	**$5,202,200**	**$4,850,000**

2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	CHOC Children's	$4,785,076	$4,250,000
2	Friends of Family Health Center	$600,000	$600,000
	Total	**$5,385,076**	**$4,850,000**

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3. Increase Access to Medication-Assisted Treatment ($6 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Coalition of Orange County Community Health Centers	$5,998,000	$6,000,000
	Total	**$5,998,000**	**$6,000,000**

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5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Serve the People	$1,000,000	$1,000,000
	Total	**$1,000,000**	**$1,000,000**

No Funding for RFPs 4 and 6

- No funding is recommended for two RFPs
  - 4. Expand Mobile Food Distribution Services ($500,000)
  - 6. Expand Access to Food Distribution Services for Older Adults ($500,000)
- Submitted proposals presented challenges
  - Did not demonstrate delivery of service to CalOptima members
  - Did not demonstrate sustainability after funds exhausted
- Funding was allocated to the Homeless Health Initiative's Clinical Field Team pilot on February 22, 2019

Internal Projects ($2.4 million)

Rank	Project	Original Request	Recommended Funding Amount
1	Whole-Child Model Assistance for Implementation and Development	$1,750,000	$1,750,000
2	Master Electronic Health Record (EHR) System	$700,000	$650,000
	Total	**$2,450,000**	**$2,400,000**

Recommended Board Actions

- Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1M for community grants and internal projects; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

CalOptima's Mission

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











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IGT Update & Proposed Funding Categories for IGT 6 & 7

Board of Directors Meeting

August 3, 2017

Cheryl Meronk

Director, Strategic Development

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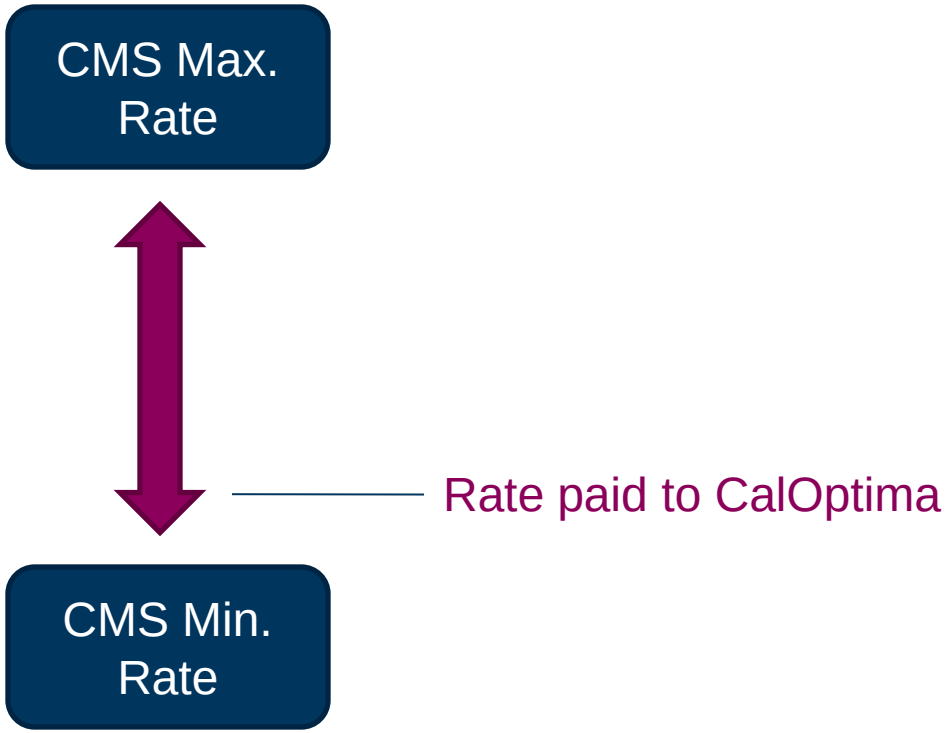
Intergovernmental Transfers (IGT) Background

- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

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Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



IGT Funds Availability and Process

- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

CalOptima Share Totals To-Date

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$6.97 M
IGT 5	$14.42 M
Total	**$47.39 M**

IGT 1 Status

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$0	Completed
Case Management System	$2,099,000	$0	Completed
Strategies to Reduce Readmissions	$533,585	($77,836)	Completed
Program for High-Risk Children	$500,000	$481,440	*Complete by 12/31/2018*
Case Management System Consulting	$866,415	$16,320	*Complete by 12/31/2017*
OCC PCC Program	$3,550,000	$0	Completed
Reallocated	*$1.1 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Total	**$11.4 M**	**$0.5 M**	

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CalOptima A Public Agency Better. Together.

IGT 2 Status

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,756,620	$0	Completed
Security Audit Remediation	$98,000	$0	Completed
Continuation of COREC	$970,000	$186,745	*Complete by 10/31/2018*
OCC PCC Program	$2,400,000	$2,400,000	*Complete by 3/31/2018*
Children's Health/ Safety Net Services	$1,300,000	$25,875	*Complete by 9/30/2017*
Wraparound Services	$1,400,000	$448,400	*Complete by 6/30/2018*
Recuperative Care	$500,000	$146,300	*Complete by 12/31/2018*
Program Administration	$100,000	$0	Completed
PACE EHR System	$80,000	$0	Completed
Total	**$8.6 M**	**$3.2 M**	

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IGT 3 Status

Project	Budget	Balance	Notes
Recuperative Care (Phase 2)	$500,000	$500,000	*Complete by 12/31/2018*
Program Administration	$165,000	$70,885	*Complete by 12/31/2017*
Reallocated	*$4.2 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Remaining Total	**$0.7 M**	**$0.6 M**	

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CalOptima A Public Agency Better. Together.

IGT 4 Status

Project	Budget	Balance	Notes
Data Warehouse Expansion	$750,000	$553,588	*Complete by 3/31/2018*
Depression Screenings	$1,000,000	$1,000,000	*Complete by 3/31/2019*
Member Health Homes	$250,000	$250,000	*Complete by 12/31/2017*
Member Health Needs Assessment	$500,000	$479,805	*Complete by 12/31/2017*
Personal Care Coordinators	$7,000,000	$6,982,240	*Complete by 6/30/2018*
Provider Portal Communications & Interconnectivity	$1,500,000	$1,472,480	*Complete by 12/31/2018*
UCI Observation Stay Payment Pilot	$750,000	$750,000	TBD
Program Administration	$529,608	$510,428	*Complete by 12/31/2018*
Reallocated	*$0*	*$5.3 M*	*Dollars reallocated from IGTs 1 & 3 (included in IGT 4 total)*
Total	**$12.3 M**	**$12.0 M**	

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CalOptima A Public Agency Better. Together.

IGT 5

- $14.4M allocated for competitive community grants
- Community grant initiatives to be developed, pending results from CalOptima's Member Health Needs Assessment

- Funding Categories:
  - Adult Mental Health
  - Children's Mental Health
  - Strengthening the Safety Net
  - Childhood Obesity
  - Improving Children's Health

Member Health Needs Assessment (IGT 5)

- Builds upon previous surveys and assessments, e.g.
  - CalOptima Group Needs Assessment
  - OC Health Care Agency – OC Health Profile
  - Hospital Community Needs Assessments
- Deeper focus on needs of diverse, underserved Medi-Cal membership, including:
  - 7 threshold languages + others never previously represented
  - Homeless
  - Mentally ill
  - Older adults
  - Persons with disabilities

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Member Health Needs Assessment (IGT 5)

- Comprehensive assessment to identify gaps in and barriers to service
  - Access to PCPs, specialists & hospitals
  - Pharmacy and lab
  - Oral health services
  - Mental health services
- Insights into social determinants of health
  - Economic stability/employment status
  - Housing status
  - Education/literacy level
  - Social isolation
  - Transportation issues
  - Cultural differences
  - Communication barriers

Estimated IGT 6 and 7 Totals

IGT	CalOptima Share
IGT 6	≈ $9.95 M (Anticipated December 2017)
IGT 7	≈ $12.16 M (Anticipated May 2018)
Total	**≈ $22.11 M**

Proposed IGT Funding Categories - IGT 6 and 7

- Funds to be used to deliver enhanced services for the Medi-Cal population



Opioid/Other Substances Overuse

- Nationwide, 78 opioid overdose deaths per day
  - 45% of Rx drug overdose deaths are Medicaid beneficiaries
- In OC, 286 opioid-related drug overdose deaths in 2016
  - Opioid dependence second leading cause of substance-related hospitalizations in OC after alcohol dependence syndrome
- Potential solutions to be funded:
  - Expand access to pain management, addiction treatment and recovery services
  - Outreach and education
  - Technical assistance to community groups working to reduce opioid and other substance overuse

Children's Mental Health

- Estimated 52,500 OC youth living with a mental health condition
- Hospitalization rate for major depression among children and youth continues to rise
- Only 32 psychiatric acute care beds in OC for adolescents, and zero for children under 12
  - New CHOC facility will add 18 beds, for ages 3-18

- Potential solutions to be funded:
  - Expand inpatient and outpatient psychiatric services capacity for children 3-18

Homeless Health

- Homelessness in OC on the rise
  - 2017 Point-in-Time count identified 4,792 homeless individuals
  - 2015 Point-in-Time count was 4,452
  - As of 2015, estimated 15,291 homeless individuals in OC
    - Approximately 11,000+ of these are CalOptima members
- Economic impact of homelessness ≈ $300M over 12-month period between 2014-15
  - Includes $121M for health care costs
- Potential solutions to be funded:
  - Expand recuperative care services
  - Increase/expand mobile health clinics

Competitive Community Grants

- Funding to fill gaps and address barriers to service beyond IGT 5 funding categories:
  - Examples of possible additional priority areas:
    - Older Adult Health
    - Dental Health
    - Persons with Disabilities
    - Maternal/perinatal Health

CalOptima Projects and Program Admin

- Approx. 10% of total IGT 6 & 7 set aside for internal priorities and program administration, e.g.:
  - Expansion of provider electronic records capabilities
  - IGT program administration
  - Grant development and administration

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Next Steps

- Gather stakeholder input
  - PAC
  - MAC
  - OCC MAC
  - Community organizations
- Develop expenditure plans for Board approval

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CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:
- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

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Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

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- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

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

Background

Intergovernmental Transfers are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the above referenced priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Priority Area	**# of LOIs**
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

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Staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

In late May 2018, CalOptima received final IGT 6 and 7 funding from DHCS, resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. IGT 6/7 funds totaled $31.1 million rather than the initially projected $22 million due to an adjustment in the enrollment numbers estimated by the California Department of Health Care Services and the higher federal match for the expansion population. On August 2, 2018, CalOptima's Board of Directors approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program; resulting in a remaining available balance of $21.1 million.

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do, and Directors Nguyen and Schoeffel, met on July 20 and July 27 to discuss the results of the 117 RFI/LOI responses for the Children's Mental Health, Opioid and other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the staff evaluation process and RFP recommendations, the Ad Hoc committee and staff determined allocation amounts and descriptions for each of the proposed six (6) Request for Proposals (RFPs). In addition, staff is recommending an allocation of IGT dollars for internal projects and program administration in the amounts indicated.

The Ad Hoc committee is recommending the following allocation of approximately $17.7 million for IGT 6 and 7 Board-approved priority areas through six (6) RFPs. Please note that multiple applicants may be selected per RFP to receive a grant award.

Community Grants

Request for Proposal	Priority Area	Allocation Amount
Access to Outpatient Mental Health Services	Children's Mental Health	~~$2,700,000~~ $4,850,000
Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	~~$7,000,000~~ $4,850,000
Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000

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Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$500,000
Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$1,000,000
Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA/Older Adult Health	$500,000
TOTAL		**$17,700,000**

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Internal Projects and Program Administration

In addition, staff is also recommending an allocation of approximately $3.4 million for internal projects and IGT program administration to manage all IGT program projects as follows:

Internal Project Examples: - IS and other infrastructure projects	$2,500,000
IGT Program Administration - Support for two (2) existing staff positions for three years - Grant Management System license, and other administrative costs for three years	$949,289 *(Approx. $317,000 per year for three years)*
TOTAL	**$3,449,289**

Staff anticipates returning with recommendations of RFP grantee awards and internal project(s) for Board approval following the completion of the community grant and internal project RFP application processes at the February 2019 Board meeting. The staff positions are Manager, Strategic Development, and Program Assistant, and the above proposed funding is in addition to $10 million allocated from IGT 6/7 for Homeless Health on August 2, 2018.

Fiscal Impact

The recommended action to approve the expenditure plan and allocation of $21.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT 6 & 7 Expenditure Plan Allocation

/s/ Michael Schrader — **Authorized Signature**

8/29/2018 — **Date**

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IGT 6 & 7 Expenditure Plan Allocation

Board of Directors Meeting

September 6, 2018

Cheryl Meronk

Director, Strategic Development

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IGT 6 & 7 - Background

- Board Established 3 New Priority Areas
  1. **Homeless Health**
  2. **Opioid and Other Substance Overuse**
  3. **Children's Mental Health**
  - ➢ Community needs identified by MHNA
  - ➢ Internal projects and IGT program administration
- Received 117 LOIs
- $10.0M allocated for County HCA for Homeless Health/WPC Recuperative Care
- Ad Hoc met to discuss recommendations for other categories

IGT 6 & 7 Funding

- **$31.1M** CalOptima's share
- **$10.0M** to County HCA for WPC Recuperative Care
- **$21.1M** remaining for recommended distribution
  - ➢ $17.7M for Community Grants
    - Six Request for Proposals (RFPs)
      - 2 RFPs in Children's Mental Health
      - 1 RFP in Opioid and other Substance Overuse
      - 3 RFPs for MHNA identified needs
  - ➢ $3.4M for Internal Projects and Program Administration

IGT 6 & 7 LOI Summary

Priority Area	# Received
Children's Mental Health	57
Homeless Health	36
Opioid & Other Substance Overuse	22
Other/multiple categories	2
Total	**117**

Children's Mental Health – 2 RFPs

RFP #	RFP Description	Funding Amount
1	Expand Access to Outpatient Mental Health Services	$2.7 million
2	Integrate Mental Health Services into Primary Care Settings	$7.0 million
	Total	**$9.7 million**

* Multiple awardees may be selected per RFP

RFP 1

Expand Access to Outpatient Children's Mental Health Services

- **Funding Amount:** $2,700,000
- **Description:**
  - Access to outpatient services
    - Create/expand school or resource center-based mental health services for children.
    - Provide services on-site, in-home, and/or afternoon/evening
    - Use an integrated model with community health workers to target vulnerable populations such as children experiencing homelessness, who have experienced traumatic incidences, homeless etc.
    - Provide additional support services to help promote stability and success

RFP 2

Integrate Children's Mental Health Services into Primary Care Settings

- **Funding Amount:** $7 million
- **Description:**
  - Integrate mental health services provided in primary care settings
    - Include behavioral health providers in clinics and/or other settings where children are provided health care services
    - Provide culturally sensitive services
    - Provide efficient and immediate access to mental health consultation
    - Provide health navigation/scheduling coordinator to ensure availability and follow-up of services

Opioid & Other Substance Overuse – 1 RFP

RFP #	RFP Description	Funding Amount
3	Increase access to Medication-Assisted Treatment	$6.0 million
	Total	**$6.0 million**

*Multiple awardees may be selected per RFP

RFP 3

Increase access to Medication-Assisted Treatment

Funding Amount: $6.0 million

- **Description:**
  - Increase access to Medication-Assisted Treatment (MAT) Programs
    - Combine behavioral and physical health services
    - Manage oversight and prescribing of FDA-approved medications and program administration
    - Provide management of patients' overall care coordination
  - Integrate pain management services
  - Ensure availability of providers/staff to deliver appropriate services
  - Establish a partnership with the Orange County Health Care Agency Drug Medi-Cal Organized Delivery System (ODS) for referrals/collaboration

Community Needs Identified by MHNA: Food Access – 3 RFPs

RFP #	RFP Description	Funding Amount
4	Expand Mobile Food Distribution Services	$500K
5	Expand Access and Food Distribution focused on Children and Families	$1 million
6	Expand Access to Older Adults Meal Programs	$500K
	Total	**$2 million**

*Multiple awardees may be selected per RFP

RFP 4

Expand Mobile Food Distribution Services

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase availability and access to healthy food options in areas of where fresh food/grocery stores are limited
  - Ensure additional mobile food trucks/vehicles to distribute healthy food options such as fresh produce/groceries that are culturally appropriate in areas of greatest need
  - Enroll members in mobile food distribution services programs
  - Provide education to prepare nutritious meals and/or pre-made meal options and simple recipes

RFP 5

Expand Access and Food Distribution Services focused on Children and Families

- **Funding Amount:** $1 million
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Access to healthy food options such as fresh fruits, vegetables and other groceries
  - Increase access to culturally appropriate food options
  - Enroll/connect members to food distribution service programs
  - Provide education and simple recipes to help families on a limited budget
  - Provide take-home meals for children/families who may not have access to cooking facilities

RFP 6

Expand Access to Older Adult Meal Programs

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase access to:
    - Healthy options such as fresh fruits, vegetables and other groceries in areas of highest need
    - Culturally appropriate food options
    - Home delivered meals
  - Enroll/connect member food distribution service programs

Internal Projects/Program Admin.

Description	Amount
IS and Other Infrastructure Projects	$2.5 million
Support for staff and administrative costs	~$315K/year (for 3 years)

Next Steps*

- IGT 6 & 7 RFP Recommendations: September 6, 2018 Board Meeting
- Release of RFPs: September 2018
- RFPs due: November 2018
- IGT Ad Hoc review of recommended grant awards: January 2019
- Recommended awards: February 2019 Board Meeting

* Dates are subject to change based on Board approval

Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

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Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

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CalOptima
A Public Agency
Better. Together.

Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

**For Medi-Cal Members*

Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
  - Physician services – primary and specialty care
  - Hospital services and tertiary care
  - Palliative care and hospice
  - Pharmacy
  - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
  - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
  - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
  - Difficulty with scheduled appointments
  - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
  - Individuals may qualify for Medi-Cal but are not enrolled

Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
  - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
  - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
    - Percentage that were CalOptima members
    - Demographics
    - Causes of death
    - Prior access to medical care
  - Identify opportunities for improvement

Strengthened System of Care

- Vision
  - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
  - Reasons for partnering with FQHCs
    - Receive CalOptima reimbursement for Medi-Cal members
    - Receive federal funding for uninsured
    - Enrollment assistance into Medi-Cal
    - Offer members education on choosing FQHC as their PCP
  - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
    - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
    - Available with extended hours
    - Go to parks, riverbeds and shelters
    - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
  - Intensive case management services
    - Section 1915(c) Home and Community Based Services waiver
      - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
  - Housing navigation and supports
    - Section 1115 waiver
      - e.g., Whole-Person Care Pilot

Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
  - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
  - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Activities in Other Counties

- Los Angeles County
  - LA County administers a flexible housing subsidy pool
  - L.A. Care provided a $4 million grant (total commitment of $20 million over 5 years) for rent subsidies to house 300 individuals
    - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
  - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
  - Housing pool not in existence today under WPC Pilot
  - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Considerations

- Establish CalOptima Homeless Response Team
  - Dedicated CalOptima resources
  - Coordinate with clinical field teams
  - Interact with Blue Shirts, health networks, providers, etc.
  - Work in the community
  - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
  - On-site in shelters
  - On the streets through clinical field teams

Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
  - ➢ Contribute to a housing pool
    - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
    - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Recommended Actions

- Authorize establishment of a clinical field team pilot program
  - Contract with any willing FQHC that meets qualifications
  - ~~CalOptima financially responsible for services regardless of health network eligibility~~
  - ~~One year pilot program~~
  - ~~Fee-for-service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to $1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
  - ~~Vehicle, equipment and supplies~~
  - ~~Staffing~~

Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
  - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed $1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

CalOptima's Mission

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











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RFP 1. Expand Access to Outpatient Children's Mental Health Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Access California Services	$ 195,000	Playing with Rainbows	Provide an innovative play-based therapeutic program that facilitates the process of healing in immigrant and/or refugee children who have been traumatized by war and migration through the use of a group counseling process involving play and art.
Boys & Girls Club of Anaheim Inc.	$ 1,331,418	Wild at Heart	A therapeutic wilderness program focused on improving children's mental health, coping skills and resilience through evidence-based outdoor experiential therapy to at-risk youth aged 12 to 18
Boys & Girls Clubs of Garden Grove	$ 325,200	Teen Mental Health Leadership Program	Reduce stigma, increase coping skills, and triage mental health care by providing peer training to community-based teen empowerment programs and education around outreach and stigma reduction.
Casa de la Familia (CDLF)	$ 1,840,968	SAUSD Mental Health Project	Provide culturally sensitive counseling, case management, outreach and parental support services to students and parents within the Santa Ana Unified School District.
Child Guidance Center, Inc	$ 1,207,053	School Based Behavioral Health Services for Military/Veteran Connected Families	Expand resource center-based behavioral health services for veteran and military connected children by providing early intervention, prevention programs and behavioral health services to children in a community-based setting. Program will also provide training to schools and implement peer navigators. Program will leverage MHSA Innovation project with the Family Resource Centers.

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Organization Name	Request ($)	Project Title	Project Description
Children's Bureau of Southern California (Children's Bureau)	$ 3,500,000	Children's Mental Health Access Collaborative	Bring together 12 outpatient mental health services providers to expand access to mental health services and increase coordination, outreach, peer support, and systems integration. Providing other Early Childhood Mental Health interventions not currently covered by MHSA funds or Medi-Cal.
CSU Fullerton Auxiliary Services Corporation	$ 4,033,395	The Early Childhood Mental Health and Wellness Program	Implement a Early Childhood Mental Health and Wellness Program through a facilitated process by a consultant and a leadership team of early care and education programs.
Gay and Lesbian Community Services Center of Orange County	$ 120,000	LGBT Center OC's Mental Health Program for Children and Youth	Provide CalOptima members ages 4-18 years with individual and family therapy as appropriate; mental health support groups for children and youth; drop-in counseling sessions for foster children; and; community groups focused on mental and emotional wellness
Hurtt Family Health Clinic	$ 745,812	Family Counseling Services for Homeless, Poor and Foster Children and Youth	Provide family counseling services to homeless families residing in Orange County Rescue Mission's transitional housing programs.
Illumination Foundation	$ 1,080,384	Children and Family In-Home Stabilization Program	Bring in-home services and individualized counseling to more families with children who are at risk of developing emotional and behavioral disorders.
Jamboree Housing Corporation	$ 692,000	Children's Behavioral Health Peer Navigation Collaboration	Pilot program to provide accessible behavioral health services for children and their families living at Jamboree's Clark Commons and surrounding Buena Park communities through an afterschool program, resident leadership training, food and nutrition workshops, and computer classes. The program will use an evidence-based peer navigation model (peer with lived experience), as well as connect members to clinical care.

Organization Name	Request ($)	Project Title	Project Description
Latino Center for Prevention & Action in Health & Welfare DBA Latino Health Access for Children with Adverse Childhood Experiences	$ 450,000	Promotora/ Community Health Worker-Facilitated Emotional Wellness and Mental Health Services	Prevention and intervention mental health program for Latino children who have had Adverse Childhood Experiences (ACE) that have resulted in trauma.
Living Success Center, Inc.	$ 1,351,000	Outreach and Education Expansion of Children's Mental Health Services	A 3-year outreach and education project to identify those in need, targeting homeless shelters and domestic violence service providers to help and counsel children who have experienced trauma .
Mariposa Women and Family Center	$ 238,898	Mariposa Children's Intervention Program (CHIP)	Use existing partnerships with local school districts, local community institutions, and low-income parents to provide programming to engage children and identify and treat mental health issues among children in Orange County.
NAMI Orange County	$ 546,380	Mental Health Education & Outreach	Offer evidence based programs such as Parent Connector, Basics Education, Progression, NAMI Connects at CHOC, and a quarterly Family Fun Event - 1K Awareness Walks for Families in collaboration with Family Resource Centers (FRC).
OC United	$ 901,500	Creating Capacity and Expanding Resilience for Children, Families, and their Communities	Expand current program engagement in local organizations, pilot a Whole-Child Treatment Team model, increase community resilience and engagement, reduce stigma, as well as increase accessibility to resources.
OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$ 685,000	The API Project HOPE	Provide mental health and wellness, culturally competent and linguistically appropriate services that include outreach and education to promote health awareness, support groups, educational trainings, resource referral and linkage, etc. Program will provide case management, in-home/community-based group counseling.

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Organization Name	Request ($)	Project Title	Project Description
Orange County Department of Education	$ 4,583,290	School-Based Student Wellness Centers	Pilot School-Based Student Wellness Centers (SWCs) within seven Orange County districts where all students can access support, resources and information on a variety of topics around mental health at their school site.
PADRES UNIDOS	$ 55,000	Early Learning Programs	Provide community-based modules such as Parents as Teachers/Early Education Modules where parents have identified that preschool-aged kids exhibit early signs of concerning behavior that can lead to future mental health challenges.
Radiant Health Centers	$ 450,000	Children's Mental Health Program Expansion	Provide outreach, community partnership building and outpatient mental health services with a focus on the subpopulations of children infected or affected by HIV and LGBTQ+ youth. The program will reduce stigma, increase awareness of mental health services and increase access to services.
Straight Talk Clinic, Inc.	$ 186,000	Children's Mental Health Support	Expand program with a pilot weekly on-site counseling services and comprehensive outreach series for children and families.
The Center for Autism & Neurodevelopmental Disorders	$ 743,672	Child Mental Health Cooperative (CMHC)	Expand child mental health services by delivering a consultative support program to providers, creating a unique interactive video-conferencing classroom and optimizing partnerships and collaborations.

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Organization Name	Request ($)	Project Title	Project Description
Vision y Compromiso	$ 875,235	Salud y Bienestar Para Todos	Collaborate with schools and community partners in Anaheim and Westminster to deliver evidence-based outreach and education strategies by engaging *promotores* to share information and resources.
Vista Community Clinic	$ 433,045	Providing School-Based Mental Health Services to La Habra Youth in Need	Project will designate 3-5 schools in La Habra as interim FQHC sites and assign three Licensed Clinical Social Workers to provide on-campus, 1-on-1 therapy to youth with mild to moderate behavioral health symptoms.
Wellness & Prevention Center	$ 153,951	Expansion of School and Community-based Youth Wellness Programming	Increase bilingual staff, support a coalition of Spanish-speaking parents and providers, and establish a presence at five new schools and community centers.
Women's Transitional Living Center, Inc.	$ 50,000	Children's Therapy Program	Counselors work with children through treatment plans that are age-appropriate, creative, and flexible, and can incorporate a range of counseling services, including individual counseling, family counseling, art therapy, sand therapy, and play therapy.

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RFP 2. Integrate Children's Mental Health Services Into Primary Care			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
AltaMed Health Services Corporation	$ 998,040	Integrating Children's Mental Health Into Primary Care in Orange County	Enhance current pediatric primary care services by integrating mental health services for children, providing referrals to early intervention, and engaging parents through community outreach and education.
CHOC Children's	$ 4,785,076	Expanding Mental Health Access and Knowledge in Pediatric Primary Care and Community Settings	Establish mental health screening, embedded mental health services, telehealth, and resource and referral for members in clinics served by CHOC Medical Group and in CHOC's Primary Care Network. Program will also provide trainings over the 3 years.
Families Together of Orange County	$ 920,000	Expanding Children's Mental Health Services	Integrate children's mental health services into primary care by offering on-site outpatient pediatric mental health care at the community health center in Tustin with outreach and education.
Friends of Family Health Center	$ 600,000	Healthy Steps	Introduce the evidence-based model HealthySteps program designed to have a specialist screen and provide families with support for common and complex concerns during a well-child visit. The HealthySteps specialist will assist with referrals and connects to additional services.
Laguna Beach Community Clinic	$ 69,109	Pediatric Mental Health: Screening and Case Management to Increase Access to Treatment	Provide screening, case management, and linkage to mental health resources and treatment for Cal-Optima members
Livingstone Community Development Corporation	$ 626,000	Integrating Children's Mental Health Services into Medical Care	Integrate outpatient mental health services into pediatric primary care screening and expand its arts and music therapy program.
Share Our Selves Corporation (SOS)	$ 200,000	Children's Mental Health Expansion Project	Expand SOS Children and Family Health Center's hours of operation from 40 to 45 hours per week and access to behavioral health outreach education and counseling services.

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IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 2,848,235	Child Psychiatry Consultation and Fellowship Program for Primary Care Providers (CPCFP)	Provide same day telephone consultation to PCPs by a child and adolescent psychiatrist in addition to rapid tele-video consult with ongoing education and training in mental health.
The Safety Net Foundation (FQHC Collaborative)	$ 2,496,000	Pediatric Integration of Behavioral Health in Primary Care for CalOptima's Safety Net: Expansion of Care Coordination, Mid-Level Provider Availability, Telehealth Options and Evidence-Based Training at Community Health Centers	Increase access to pediatric mental health care through the expansion of mid-level providers, the exploration of telemedicine and the integration of behavioral health with pediatric primary care.
Vista Community Clinic	$ 426,422	Enhancing Children's Mental Health via Primary Care Integration and Community Outreach in La Habra	A primary care - mental health integration project for Hispanic youth and their families living in and around the City of La Habra.

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IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

RFP 3. Increase Access to Medication-Assisted Treatment			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Ahura Healthcare	$ 2,850,000	Medicated-Assisted Treatment (MAT)	Provide comprehensive mental health and addiction medicine care with the use of Medicated-Assisted Treatment (MAT) therapy such as Suboxone, Methadone, and Naltrexone provided by licensed physicians along with mental health services and counseling.
Bright Heart Health	$ 3,915,000	Opioid Use Disorder OnDemand Treatment	Provide complete telehealth MAT services through Data2000 physicians, nurse practitioners, and physician assistants.
Central City Community Health Center	$ 930,000	CCCHC SUD-MAT Services & Educational Program	Expand access to and enhance existing, integrated and evidenced-based, SUD-MAT clinical care program with the City of Anaheim Health Center as the "hub" with services available via in-person provider or telehealth. The project includes providing service through mobile units.
Clean Path Recovery LLC	$ 5,998,484	Clean Path Recovery MAT Program	Program will use FDA approved medications in combination with counseling, holistic and behavioral therapies.

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IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
Coalition of Orange County Community Health Centers	$ 5,998,000	MATCONNECT: A County-wide Collaborative for MAT Expansion to CalOptima Members at Community Health Centers	Build capacity and expand access and delivery of MAT services by bridging integration gaps in the Substance Use Disorder (SUD) system of care in Orange County. Implement a localized version of the DHCS Hub and Spoke model and build internal capacity for increased MAT services and access for each of the Spoke locations.
Friends of Family Health Center	$ 600,000	Medication Assisted Treatment	Introduce Medication Assisted Treatment (MAT) with emphasis on opioid addiction with an individually tailored and extensive care coordination for patients
Livingstone Community Development Corporation	$ 808,000	Establishing a Substance Abuse Program with Medication-Assisted Treatment	Establish a new medication-assisted treatment (MAT) program which will be integrated with physical and behavioral health services and include supervised exercise and acupuncture treatments.
Serve the People	$ 1,485,000	Integrated Behavioral Health for Hard To Reach Populations	Purchase and staff Integrated Services (IS) Mobile Clinics and provide integrated whole-person care to individuals at the Courtyard and to others in addiction treatment facilities.
Share Our Selves Corporation (SOS)	$ 200,000	SOS Behavioral Health Expansion Project	Increase capacity to provide comprehensive behavioral health and case management services via telehealth technology and new medical/behavioral health mobile unit at homeless shelters operated by SOS's partner agencies throughout the county.

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Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 1,825,518	Establishing and Increasing the capacity of a Medication Assisted Treatment program through a Hub-and-Spoke model for CalOptima patients	Establish and expand the capacity of medication-assisted treatment (MAT) within Orange County. The hubs will be the Zephyr Medical Group in Laguna Hills and UC Irvine Medical Center.

RFP 4. Expand Mobile Food Distribution Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 250,000	OC Food Bank Mobile Food Trolley	Project will use OC Food Bank's mobile food trolley to provide a variety of food that is distributed on a first-come, first-served basis and may include items such as produce, non-perishable goods and protein.

RFP 5. Expand Access to Food Distribution Services Focused on Children and Families			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Global Operations & Development / Giving Children Hope	$ 50,000	We've Got Your Back (WGYB)	Food distribution program fills and distributes more than 1,100 backpacks of nutritious food including fruits and vegetables on a weekly basis.
LiveHealthy OC	$ 990,000	The LiveHeathy OC "Farmacy" Project - Establishing a Sustainable Farm to Clinic Network to Increase Access to Fresh, Healthy Foods for Underserved and Low Income Patients	Expands current access to fresh fruits and vegetables using a sustainable farm-to-clinic produce delivery system – the "farmacy" – at five community health centers through a monthly mobile farmers' market.
Livingstone Community Development Corporation	$ 300,000	Expanding Food Access for Children and Families	Expanding food pantry and integrate access to the food pantry into Group Medical Visits with CalOptima members suffering from diabetes, obesity, hypertension, and/or heart disease
Serve the People	$ 1,000,000	OC Food Oasis Partnership	Expand mobile food distribution to five FQHC sites and shelters that serve homeless persons. The strategy is to include healthy food and meal distribution, nutrition education, a 'food as medicine' prescription food box program for patients with chronic disease, and demonstrations on healthy food preparation and cooking, plus outreach and case management to services establishing a system to address social determinants of health.

Organization Name	Request ($)	Project Title	Project Description
Vista Community Clinic	$ 289,533	In the Kitchen: An Innovative Education/Food Distribution Program in La Habra	Develop a teaching kitchen that will provide nutrition education and hands-on cooking lessons to participants (accommodate groups of 12 residents).

RFP 6. Expand Access to Food Distribution Services for Older Adults			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 231,514	Farm-to Seniors Food Distribution Program	Provide fresh, healthy food to older adult CalOptima members through a network of 17 distribution sites.
Multi-Ethnic Collaborative of Community Agencies	$ 500,000	Increasing Food Access for Underserved Multi-Ethnic Older Adults	Expand food access distribution at the seven MECCA sites by building the volunteer base capacity, expand outreach, and provide culturally appropriate education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

17. Consider Ratification of Amendments to the AltaMed Health Services Corporation Medi-Cal Health Network Contract, and Expenditures for Whole-Child Model Program Implementation

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

1. Ratify amendments to the AltaMed Health Services Corporation Medi-Cal health network contract, to include payment by CalOptima of startup costs associated with the Whole-Child Model program; and,
2. Ratify the expenditure of up to $1.75 million in IGT 6 and 7 funds for implementation.

Background

The California Children's Services Program (CCS) is a statewide program, providing medical care, case management, physical/occupational therapy, and financial assistance for children up to age 21 meeting financial and health condition eligibility criteria. Following the approval of Senate Bill 586 in September 2016, the Department of Healthcare Services (DHCS) was given the authority to incorporate a number of CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS), referred to as the Whole Child Model (WCM). CalOptima began the process of transitioning its Medi-Cal Health Networks in June 2018, with implementation going live as of July 1, 2019. The importance of a successful WCM transition cannot be overstated, as it directly impacts the wellbeing of CalOptima's most at-risk pediatric members.

IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 6 and 7 funds were received in May 2018 from the Department of Health Care Services (DHCS) totaled $31.1 million. After initial disbursements of $10 million for the Homeless Health Initiative, the Board authorized the remaining balance of $21.1 million to be used for community grants, internal initiatives and program administration. On August 1, 2019, the Board authorized $1.75 million for the Whole Child Model Assistance for Implementation and Development (WCM AID), which was approved as an internal initiative. The funds were designated to aid health networks in developing and implementing a successful delivery system for the WCM program.

Discussion

Health networks were required to cover a portion of the WCM program's startup expenses incurred before the launch on July 1, 2019. Following the Board's August 1, 2019 approval of the IGT 6 and 7 allocation for WCM startup costs, health networks were notified that they would receive a one-time, fixed payment of $50,000, plus applicable variable costs up to the amount allowed per network based on the number of WCM assigned members. CalOptima provided criteria for reimbursement, including receipt of attestations demonstrating that the costs were incurred prior to the WCM program go-live date of July 1, 2019, and that expenditures fall within the specified categories of:

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- Staffing, recruitment and training.
- Systems and infrastructure.
- Other expenses such as educational materials, notices, etc.

Staff seeks authority to ratify contract amendments and expenditures for the AltaMed Health Services Corporation Medi-Cal health network, to aid with start-up costs and implementation of the WCM program.

Fiscal Impact

The recommended action to amend Medi-Cal health network contracts to include disbursement of IGT 6 and 7 funds for WCM Assistance for Implementation and Development has no fiscal impact to CalOptima's operating budget. The Board authorized the allocation of $1.75 million from IGT 6 and 7 funds for this purpose at the August 1, 2019, meeting. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

The recommended action ensures CalOptima's Medi-Cal health network contracts are updated to reflect receipt of IGT 6 and 7 funds for reimbursement of startup costs associated with the WCM program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 3, 2017; Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot
3. Previous Board Action dated August 1, 2019; Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Health Network	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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Attachment to the December 5, 2019 Board of Directors Meeting -- Agenda Item 17

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
14. Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

Contact
Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions
1. Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1 million for community grants and internal projects; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into grant contracts with the recommended community grantees.

Background
Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1 – 7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On August 3, 2017, CalOptima's Board of Directors approved the recommendation to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

Subsequently, CalOptima released Requests for Information/Letters of Interest (RFI/LOI) from organizations to help determine funding allocation amounts for the priority areas and received 117 responses. Initial projections of available IGT 6/7 funds were estimated to be $22.1 million.

In May 2018, CalOptima received final IGT 6 and 7 funding from the Department of Health Care Services (DHCS), resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. On August 2, 2018, the Board approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program. On September 6, 2018 the Board authorized the remaining available balance of $21.1 million to be used for community grants, internal initiatives and program administration.

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Subsequently, at its February 22, 2019 Special Meeting, the Board approved funds to be reallocated to the Clinical Field Teams Pilot for the Homeless Health Initiatives. The funds were reallocated from Requests for Proposals (RFP) 4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) in the total amount of $1 million which were not recommended for grants. In addition, $100,000 IGT 6 funds previously approved by the Board were reallocated from Internal Initiatives to the Clinical Field Teams Pilot. The reallocations were ratified at the April 4, 2019 Board meeting.

Proposed Allocation for community grants and internal initiatives is as follows:

Community Grants

Request for Proposal	Priority Area	Allocation Amount
1. Access to Outpatient Mental Health Services	Children's Mental Health	$4,850,000
2. Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	$4,850,000
3. Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000
4. Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
5. Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA	$1,000,000
6. Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
TOTAL		**$16,700,000**

Internal Initiatives

Internal Project Examples: - IS and other infrastructure projects as summarized below.	$2,400,000
TOTAL	**$2,400,000**

External subject matter experts and staff performed an examination of the RFP responses and evaluated them based on the following criteria:

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- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do and Director DiLuigi, met to discuss the results of the 54 RFP responses for the Children's Mental Health and Opioid and Other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the evaluation committees results and RFP recommendations, the Ad Hoc committee is recommending the following allocation of approximately $16.7 million for IGT 6 and 7 Board-approved priority areas through four (4) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	Children's Bureau of Southern California	$3,390,000
	OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$685,000
	Boys & Girls Clubs of Garden Grove	$325,000
	Jamboree Housing	$450,000
RFP 2. Integrate Children's Mental Health Services into Primary Care ($4.85 million)	CHOC Children's	$4,250,000
	Friends of Family Health Center	$600,000
RFP 3. Increase Access to Medication-Assisted Treatment ($6 million)	Coalition of Orange County Community Health Center	$6,000,000
RFP 5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	Serve the People	$1,000,000
TOTAL		**$16,700,000**

As noted above, the ad hoc is not recommending grants for two of the RFP categories (4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) and the associated funding was previously reallocated to the Clinical Field Teams Pilot at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

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Internal Initiatives
In addition, staff reviewed four internal applications and is recommending an allocation of $2.4 million for internal projects. Funding of $100,000 from the Internal Initiatives budget was reallocated to the Clinical Field Team pilot for the Homeless Health Initiatives at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Project	Amount
Whole Child Model Assistance for Implementation and Development (WCM AID)	$1,750,000
Master Electronic Health Record (EHR) System	$650,000
TOTAL	**$2,400,000**

Fiscal Impact
The recommended action to approve the allocation of $19.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, will work with our provider and community partners to address the health care needs of the members we serve.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: IGT 6 and 7 Expenditure Plan Allocation
2. CalOptima Board Action dated August 3, 2017, Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7
3. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Fund
4. CalOptima Board Action dated September 6, 2018, Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants
5. CalOptima Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but no limited to, Funding and Provider Contracting
6. IGT 6/7 RFP Responses

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

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IGT 6 and 7 Community Grant Award Recommendations

August 1, 2019

Candice Gomez
Executive Director, Program Implementation

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Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
  - IGTs 8–9: Funds must be used for Medi-Cal covered services for the Medi-Cal population
- CalOptima Board of Directors approved IGT 6 and 7 priority areas for community-based funding opportunities
  - Children's Mental Health
  - Homeless Health
  - Opioid and Other Substance Overuse
  - Other Needs Identified by the Member Health Needs Assessment

Background (cont.)

- Received 117 RFIs to identify strategies for each priority area
- IGT 6 and 7 funds of $31.1 million were received in May 2018
  - $10 million approved for recuperative care services in August 2018
  - $21.1 million allocated for community grants, internal initiatives and program administration in September 2018
    - $17.7 million in community grants
    - $2.5 million in internal initiatives
    - $900,000 in program administration (over 3 years)
- Released RFPs, evaluated responses and conducted site visits from September 2018–January 2019

RFP Evaluation Criteria

- Organizational capacity and financial condition
- Statement of need that describes the specific issue or problem and the proposed program/solution
- Impact on CalOptima members with outreach and education strategies
- Efficient and effective use of potential grant funds for proposed program/solution

Site Visits

- Subject matter experts and staff conducted site visits to finalist organizations
- Questions were asked to:
  - Better understand the organization, current services provided and the proposed project
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
  - Determine if there are any concerns with awarding a grant to the organization

RFP Summary

RFP	Total Received	Total Recommended
1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	26	4
2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)	10	2
3. Increase Access to Medication-Assisted Treatment ($6 million)	10	1
4. Expand Mobile Food Distribution Services ($500,000)	1	0
5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	5	1
6. Expand Access to Food Distribution Services for Older Adults ($500,000)	2	0
Total	**54**	**8**

1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Children's Bureau of Southern California	$3,500,000	$3,390,000
2	OCAPICA (Orange County Asian & Pacific Islander Community Alliance Inc.)	$685,000	$685,000
3	Boys & Girls Club of Garden Grove	$325,200	$325,000
4	Jamboree Housing	$692,000	$450,000
	Total	**$5,202,200**	**$4,850,000**

2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	CHOC Children's	$4,785,076	$4,250,000
2	Friends of Family Health Center	$600,000	$600,000
	Total	**$5,385,076**	**$4,850,000**

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3. Increase Access to Medication-Assisted Treatment ($6 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Coalition of Orange County Community Health Centers	$5,998,000	$6,000,000
	Total	**$5,998,000**	**$6,000,000**

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5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Serve the People	$1,000,000	$1,000,000
	Total	**$1,000,000**	**$1,000,000**

No Funding for RFPs 4 and 6

- No funding is recommended for two RFPs
  - 4. Expand Mobile Food Distribution Services ($500,000)
  - 6. Expand Access to Food Distribution Services for Older Adults ($500,000)
- Submitted proposals presented challenges
  - Did not demonstrate delivery of service to CalOptima members
  - Did not demonstrate sustainability after funds exhausted
- Funding was allocated to the Homeless Health Initiative's Clinical Field Team pilot on February 22, 2019

Internal Projects ($2.4 million)

Rank	Project	Original Request	Recommended Funding Amount
1	Whole-Child Model Assistance for Implementation and Development	$1,750,000	$1,750,000
2	Master Electronic Health Record (EHR) System	$700,000	$650,000
	Total	**$2,450,000**	**$2,400,000**

Recommended Board Actions

- Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1M for community grants and internal projects; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

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











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IGT Update & Proposed Funding Categories for IGT 6 & 7

Board of Directors Meeting

August 3, 2017

Cheryl Meronk

Director, Strategic Development

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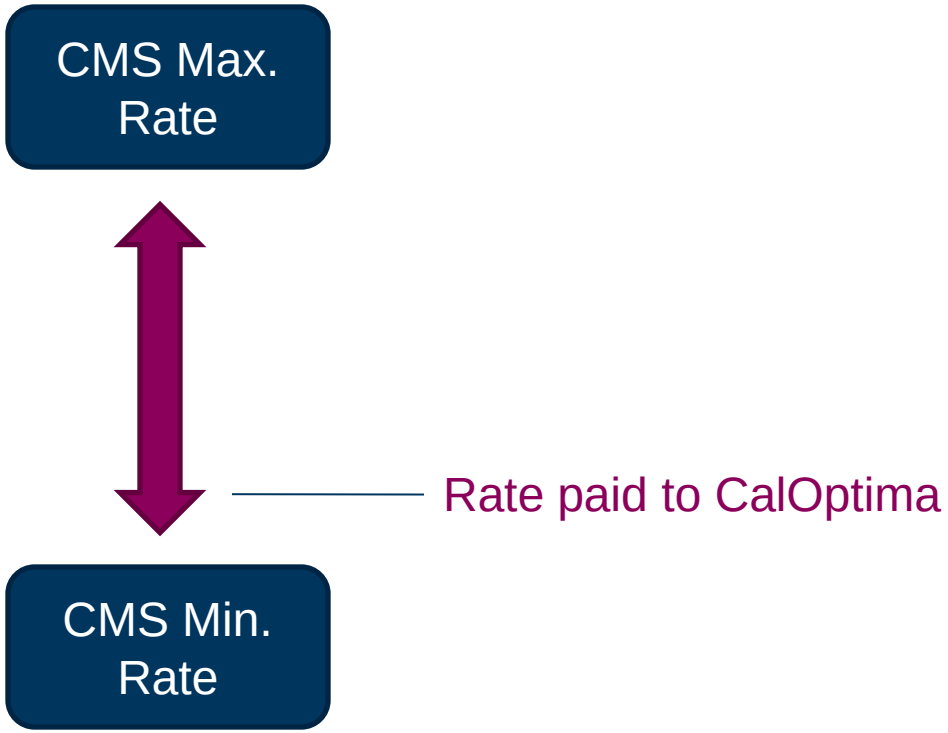
Intergovernmental Transfers (IGT) Background

- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

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Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



IGT Funds Availability and Process

- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

CalOptima Share Totals To-Date

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$6.97 M
IGT 5	$14.42 M
Total	**$47.39 M**

IGT 1 Status

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$0	Completed
Case Management System	$2,099,000	$0	Completed
Strategies to Reduce Readmissions	$533,585	($77,836)	Completed
Program for High-Risk Children	$500,000	$481,440	*Complete by 12/31/2018*
Case Management System Consulting	$866,415	$16,320	*Complete by 12/31/2017*
OCC PCC Program	$3,550,000	$0	Completed
Reallocated	*$1.1 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Total	**$11.4 M**	**$0.5 M**	

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CalOptima A Public Agency Better. Together.

IGT 2 Status

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,756,620	$0	Completed
Security Audit Remediation	$98,000	$0	Completed
Continuation of COREC	$970,000	$186,745	*Complete by 10/31/2018*
OCC PCC Program	$2,400,000	$2,400,000	*Complete by 3/31/2018*
Children's Health/ Safety Net Services	$1,300,000	$25,875	*Complete by 9/30/2017*
Wraparound Services	$1,400,000	$448,400	*Complete by 6/30/2018*
Recuperative Care	$500,000	$146,300	*Complete by 12/31/2018*
Program Administration	$100,000	$0	Completed
PACE EHR System	$80,000	$0	Completed
Total	**$8.6 M**	**$3.2 M**	

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IGT 3 Status

Project	Budget	Balance	Notes
Recuperative Care (Phase 2)	$500,000	$500,000	*Complete by 12/31/2018*
Program Administration	$165,000	$70,885	*Complete by 12/31/2017*
Reallocated	*$4.2 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Remaining Total	**$0.7 M**	**$0.6 M**	

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IGT 4 Status

Project	Budget	Balance	Notes
Data Warehouse Expansion	$750,000	$553,588	*Complete by 3/31/2018*
Depression Screenings	$1,000,000	$1,000,000	*Complete by 3/31/2019*
Member Health Homes	$250,000	$250,000	*Complete by 12/31/2017*
Member Health Needs Assessment	$500,000	$479,805	*Complete by 12/31/2017*
Personal Care Coordinators	$7,000,000	$6,982,240	*Complete by 6/30/2018*
Provider Portal Communications & Interconnectivity	$1,500,000	$1,472,480	*Complete by 12/31/2018*
UCI Observation Stay Payment Pilot	$750,000	$750,000	TBD
Program Administration	$529,608	$510,428	*Complete by 12/31/2018*
Reallocated	*$0*	*$5.3 M*	*Dollars reallocated from IGTs 1 & 3 (included in IGT 4 total)*
Total	**$12.3 M**	**$12.0 M**	

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IGT 5

- $14.4M allocated for competitive community grants
- Community grant initiatives to be developed, pending results from CalOptima's Member Health Needs Assessment

- Funding Categories:
  - Adult Mental Health
  - Children's Mental Health
  - Strengthening the Safety Net
  - Childhood Obesity
  - Improving Children's Health

Member Health Needs Assessment (IGT 5)

- Builds upon previous surveys and assessments, e.g.
  - CalOptima Group Needs Assessment
  - OC Health Care Agency – OC Health Profile
  - Hospital Community Needs Assessments
- Deeper focus on needs of diverse, underserved Medi-Cal membership, including:
  - 7 threshold languages + others never previously represented
  - Homeless
  - Mentally ill
  - Older adults
  - Persons with disabilities

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Member Health Needs Assessment (IGT 5)

- Comprehensive assessment to identify gaps in and barriers to service
  - Access to PCPs, specialists & hospitals
  - Pharmacy and lab
  - Oral health services
  - Mental health services
- Insights into social determinants of health
  - Economic stability/employment status
  - Housing status
  - Education/literacy level
  - Social isolation
  - Transportation issues
  - Cultural differences
  - Communication barriers

Estimated IGT 6 and 7 Totals

IGT	CalOptima Share
IGT 6	≈ $9.95 M (Anticipated December 2017)
IGT 7	≈ $12.16 M (Anticipated May 2018)
Total	**≈ $22.11 M**

Proposed IGT Funding Categories - IGT 6 and 7

- Funds to be used to deliver enhanced services for the Medi-Cal population



Opioid/Other Substances Overuse

- Nationwide, 78 opioid overdose deaths per day
  - 45% of Rx drug overdose deaths are Medicaid beneficiaries
- In OC, 286 opioid-related drug overdose deaths in 2016
  - Opioid dependence second leading cause of substance-related hospitalizations in OC after alcohol dependence syndrome
- Potential solutions to be funded:
  - Expand access to pain management, addiction treatment and recovery services
  - Outreach and education
  - Technical assistance to community groups working to reduce opioid and other substance overuse

Children's Mental Health

- Estimated 52,500 OC youth living with a mental health condition
- Hospitalization rate for major depression among children and youth continues to rise
- Only 32 psychiatric acute care beds in OC for adolescents, and zero for children under 12
  - New CHOC facility will add 18 beds, for ages 3-18

- Potential solutions to be funded:
  - Expand inpatient and outpatient psychiatric services capacity for children 3-18

Homeless Health

- Homelessness in OC on the rise
  - 2017 Point-in-Time count identified 4,792 homeless individuals
  - 2015 Point-in-Time count was 4,452
  - As of 2015, estimated 15,291 homeless individuals in OC
    - Approximately 11,000+ of these are CalOptima members
- Economic impact of homelessness ≈ $300M over 12-month period between 2014-15
  - Includes $121M for health care costs
- Potential solutions to be funded:
  - Expand recuperative care services
  - Increase/expand mobile health clinics

Competitive Community Grants

- Funding to fill gaps and address barriers to service beyond IGT 5 funding categories:
  - Examples of possible additional priority areas:
    - Older Adult Health
    - Dental Health
    - Persons with Disabilities
    - Maternal/perinatal Health

CalOptima Projects and Program Admin

- Approx. 10% of total IGT 6 & 7 set aside for internal priorities and program administration, e.g.:
  - Expansion of provider electronic records capabilities
  - IGT program administration
  - Grant development and administration

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Next Steps

- Gather stakeholder input
  - PAC
  - MAC
  - OCC MAC
  - Community organizations
- Develop expenditure plans for Board approval

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:
- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

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Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

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- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

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

Background

Intergovernmental Transfers are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the above referenced priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Priority Area	**# of LOIs**
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

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Staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

In late May 2018, CalOptima received final IGT 6 and 7 funding from DHCS, resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. IGT 6/7 funds totaled $31.1 million rather than the initially projected $22 million due to an adjustment in the enrollment numbers estimated by the California Department of Health Care Services and the higher federal match for the expansion population. On August 2, 2018, CalOptima's Board of Directors approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program; resulting in a remaining available balance of $21.1 million.

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do, and Directors Nguyen and Schoeffel, met on July 20 and July 27 to discuss the results of the 117 RFI/LOI responses for the Children's Mental Health, Opioid and other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the staff evaluation process and RFP recommendations, the Ad Hoc committee and staff determined allocation amounts and descriptions for each of the proposed six (6) Request for Proposals (RFPs). In addition, staff is recommending an allocation of IGT dollars for internal projects and program administration in the amounts indicated.

The Ad Hoc committee is recommending the following allocation of approximately $17.7 million for IGT 6 and 7 Board-approved priority areas through six (6) RFPs. Please note that multiple applicants may be selected per RFP to receive a grant award.

Community Grants

Request for Proposal	Priority Area	Allocation Amount
Access to Outpatient Mental Health Services	Children's Mental Health	~~$2,700,000~~ $4,850,000
Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	~~$7,000,000~~ $4,850,000
Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000

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Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$500,000
Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$1,000,000
Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA/Older Adult Health	$500,000
TOTAL		**$17,700,000**

Rev. 9/6/18

Internal Projects and Program Administration

In addition, staff is also recommending an allocation of approximately $3.4 million for internal projects and IGT program administration to manage all IGT program projects as follows:

Internal Project Examples: - IS and other infrastructure projects	$2,500,000
IGT Program Administration - Support for two (2) existing staff positions for three years - Grant Management System license, and other administrative costs for three years	$949,289 *(Approx. $317,000 per year for three years)*
TOTAL	**$3,449,289**

Staff anticipates returning with recommendations of RFP grantee awards and internal project(s) for Board approval following the completion of the community grant and internal project RFP application processes at the February 2019 Board meeting. The staff positions are Manager, Strategic Development, and Program Assistant, and the above proposed funding is in addition to $10 million allocated from IGT 6/7 for Homeless Health on August 2, 2018.

Fiscal Impact

The recommended action to approve the expenditure plan and allocation of $21.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT 6 & 7 Expenditure Plan Allocation

/s/ Michael Schrader — **Authorized Signature**

8/29/2018 — **Date**

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IGT 6 & 7 Expenditure Plan Allocation

Board of Directors Meeting

September 6, 2018

Cheryl Meronk

Director, Strategic Development

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IGT 6 & 7 - Background

- Board Established 3 New Priority Areas
  1. **Homeless Health**
  2. **Opioid and Other Substance Overuse**
  3. **Children's Mental Health**
  - ➢ Community needs identified by MHNA
  - ➢ Internal projects and IGT program administration
- Received 117 LOIs
- $10.0M allocated for County HCA for Homeless Health/WPC Recuperative Care
- Ad Hoc met to discuss recommendations for other categories

IGT 6 & 7 Funding

- **$31.1M** CalOptima's share
- **$10.0M** to County HCA for WPC Recuperative Care
- **$21.1M** remaining for recommended distribution
  - ➢ $17.7M for Community Grants
    - Six Request for Proposals (RFPs)
      - 2 RFPs in Children's Mental Health
      - 1 RFP in Opioid and other Substance Overuse
      - 3 RFPs for MHNA identified needs
  - ➢ $3.4M for Internal Projects and Program Administration

IGT 6 & 7 LOI Summary

Priority Area	# Received
Children's Mental Health	57
Homeless Health	36
Opioid & Other Substance Overuse	22
Other/multiple categories	2
Total	**117**

Children's Mental Health – 2 RFPs

RFP #	RFP Description	Funding Amount
1	Expand Access to Outpatient Mental Health Services	$2.7 million
2	Integrate Mental Health Services into Primary Care Settings	$7.0 million
	Total	**$9.7 million**

* Multiple awardees may be selected per RFP

RFP 1

Expand Access to Outpatient Children's Mental Health Services

- **Funding Amount:** $2,700,000
- **Description:**
  - Access to outpatient services
    - Create/expand school or resource center-based mental health services for children.
    - Provide services on-site, in-home, and/or afternoon/evening
    - Use an integrated model with community health workers to target vulnerable populations such as children experiencing homelessness, who have experienced traumatic incidences, homeless etc.
    - Provide additional support services to help promote stability and success

RFP 2

Integrate Children's Mental Health Services into Primary Care Settings

- **Funding Amount:** $7 million
- **Description:**
  - Integrate mental health services provided in primary care settings
    - Include behavioral health providers in clinics and/or other settings where children are provided health care services
    - Provide culturally sensitive services
    - Provide efficient and immediate access to mental health consultation
    - Provide health navigation/scheduling coordinator to ensure availability and follow-up of services

Opioid & Other Substance Overuse – 1 RFP

RFP #	RFP Description	Funding Amount
3	Increase access to Medication-Assisted Treatment	$6.0 million
	Total	**$6.0 million**

*Multiple awardees may be selected per RFP

RFP 3

Increase access to Medication-Assisted Treatment

Funding Amount: $6.0 million

- **Description:**
  - Increase access to Medication-Assisted Treatment (MAT) Programs
    - Combine behavioral and physical health services
    - Manage oversight and prescribing of FDA-approved medications and program administration
    - Provide management of patients' overall care coordination
  - Integrate pain management services
  - Ensure availability of providers/staff to deliver appropriate services
  - Establish a partnership with the Orange County Health Care Agency Drug Medi-Cal Organized Delivery System (ODS) for referrals/collaboration

Community Needs Identified by MHNA: Food Access – 3 RFPs

RFP #	RFP Description	Funding Amount
4	Expand Mobile Food Distribution Services	$500K
5	Expand Access and Food Distribution focused on Children and Families	$1 million
6	Expand Access to Older Adults Meal Programs	$500K
	Total	**$2 million**

*Multiple awardees may be selected per RFP

RFP 4

Expand Mobile Food Distribution Services

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase availability and access to healthy food options in areas of where fresh food/grocery stores are limited
  - Ensure additional mobile food trucks/vehicles to distribute healthy food options such as fresh produce/groceries that are culturally appropriate in areas of greatest need
  - Enroll members in mobile food distribution services programs
  - Provide education to prepare nutritious meals and/or pre-made meal options and simple recipes

RFP 5

Expand Access and Food Distribution Services focused on Children and Families

- **Funding Amount:** $1 million
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Access to healthy food options such as fresh fruits, vegetables and other groceries
  - Increase access to culturally appropriate food options
  - Enroll/connect members to food distribution service programs
  - Provide education and simple recipes to help families on a limited budget
  - Provide take-home meals for children/families who may not have access to cooking facilities

RFP 6

Expand Access to Older Adult Meal Programs

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase access to:
    - Healthy options such as fresh fruits, vegetables and other groceries in areas of highest need
    - Culturally appropriate food options
    - Home delivered meals
  - Enroll/connect member food distribution service programs

Internal Projects/Program Admin.

Description	Amount
IS and Other Infrastructure Projects	$2.5 million
Support for staff and administrative costs	~$315K/year (for 3 years)

Next Steps*

- IGT 6 & 7 RFP Recommendations: September 6, 2018 Board Meeting
- Release of RFPs: September 2018
- RFPs due: November 2018
- IGT Ad Hoc review of recommended grant awards: January 2019
- Recommended awards: February 2019 Board Meeting

* Dates are subject to change based on Board approval

Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

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Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

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CalOptima
A Public Agency
Better. Together.

Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

**For Medi-Cal Members*

Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
  - Physician services – primary and specialty care
  - Hospital services and tertiary care
  - Palliative care and hospice
  - Pharmacy
  - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
  - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
  - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
  - Difficulty with scheduled appointments
  - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
  - Individuals may qualify for Medi-Cal but are not enrolled

Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
  - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
  - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
    - Percentage that were CalOptima members
    - Demographics
    - Causes of death
    - Prior access to medical care
  - Identify opportunities for improvement

Strengthened System of Care

- Vision
  - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
  - Reasons for partnering with FQHCs
    - Receive CalOptima reimbursement for Medi-Cal members
    - Receive federal funding for uninsured
    - Enrollment assistance into Medi-Cal
    - Offer members education on choosing FQHC as their PCP
  - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
    - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
    - Available with extended hours
    - Go to parks, riverbeds and shelters
    - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
  - Intensive case management services
    - Section 1915(c) Home and Community Based Services waiver
      - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
  - Housing navigation and supports
    - Section 1115 waiver
      - e.g., Whole-Person Care Pilot

Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
  - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
  - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Activities in Other Counties

- Los Angeles County
  - LA County administers a flexible housing subsidy pool
  - L.A. Care provided a $4 million grant (total commitment of $20 million over 5 years) for rent subsidies to house 300 individuals
    - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
  - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
  - Housing pool not in existence today under WPC Pilot
  - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Considerations

- Establish CalOptima Homeless Response Team
  - Dedicated CalOptima resources
  - Coordinate with clinical field teams
  - Interact with Blue Shirts, health networks, providers, etc.
  - Work in the community
  - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
  - On-site in shelters
  - On the streets through clinical field teams

Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
  - ➢ Contribute to a housing pool
    - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
    - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Recommended Actions

- Authorize establishment of a clinical field team pilot program
  - Contract with any willing FQHC that meets qualifications
  - ~~CalOptima financially responsible for services regardless of health network eligibility~~
  - ~~One year pilot program~~
  - ~~Fee-for-service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to $1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
  - ~~Vehicle, equipment and supplies~~
  - ~~Staffing~~

Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
  - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed $1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

CalOptima's Mission

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











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RFP 1. Expand Access to Outpatient Children's Mental Health Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Access California Services	$ 195,000	Playing with Rainbows	Provide an innovative play-based therapeutic program that facilitates the process of healing in immigrant and/or refugee children who have been traumatized by war and migration through the use of a group counseling process involving play and art.
Boys & Girls Club of Anaheim Inc.	$ 1,331,418	Wild at Heart	A therapeutic wilderness program focused on improving children's mental health, coping skills and resilience through evidence-based outdoor experiential therapy to at-risk youth aged 12 to 18
Boys & Girls Clubs of Garden Grove	$ 325,200	Teen Mental Health Leadership Program	Reduce stigma, increase coping skills, and triage mental health care by providing peer training to community-based teen empowerment programs and education around outreach and stigma reduction.
Casa de la Familia (CDLF)	$ 1,840,968	SAUSD Mental Health Project	Provide culturally sensitive counseling, case management, outreach and parental support services to students and parents within the Santa Ana Unified School District.
Child Guidance Center, Inc	$ 1,207,053	School Based Behavioral Health Services for Military/Veteran Connected Families	Expand resource center-based behavioral health services for veteran and military connected children by providing early intervention, prevention programs and behavioral health services to children in a community-based setting. Program will also provide training to schools and implement peer navigators. Program will leverage MHSA Innovation project with the Family Resource Centers.

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Organization Name	Request ($)	Project Title	Project Description
Children's Bureau of Southern California (Children's Bureau)	$ 3,500,000	Children's Mental Health Access Collaborative	Bring together 12 outpatient mental health services providers to expand access to mental health services and increase coordination, outreach, peer support, and systems integration. Providing other Early Childhood Mental Health interventions not currently covered by MHSA funds or Medi-Cal.
CSU Fullerton Auxiliary Services Corporation	$ 4,033,395	The Early Childhood Mental Health and Wellness Program	Implement a Early Childhood Mental Health and Wellness Program through a facilitated process by a consultant and a leadership team of early care and education programs.
Gay and Lesbian Community Services Center of Orange County	$ 120,000	LGBT Center OC's Mental Health Program for Children and Youth	Provide CalOptima members ages 4-18 years with individual and family therapy as appropriate; mental health support groups for children and youth; drop-in counseling sessions for foster children; and; community groups focused on mental and emotional wellness
Hurtt Family Health Clinic	$ 745,812	Family Counseling Services for Homeless, Poor and Foster Children and Youth	Provide family counseling services to homeless families residing in Orange County Rescue Mission's transitional housing programs.
Illumination Foundation	$ 1,080,384	Children and Family In-Home Stabilization Program	Bring in-home services and individualized counseling to more families with children who are at risk of developing emotional and behavioral disorders.
Jamboree Housing Corporation	$ 692,000	Children's Behavioral Health Peer Navigation Collaboration	Pilot program to provide accessible behavioral health services for children and their families living at Jamboree's Clark Commons and surrounding Buena Park communities through an afterschool program, resident leadership training, food and nutrition workshops, and computer classes. The program will use an evidence-based peer navigation model (peer with lived experience), as well as connect members to clinical care.

Organization Name	Request ($)	Project Title	Project Description
Latino Center for Prevention & Action in Health & Welfare DBA Latino Health Access for Children with Adverse Childhood Experiences	$ 450,000	Promotora/ Community Health Worker-Facilitated Emotional Wellness and Mental Health Services	Prevention and intervention mental health program for Latino children who have had Adverse Childhood Experiences (ACE) that have resulted in trauma.
Living Success Center, Inc.	$ 1,351,000	Outreach and Education Expansion of Children's Mental Health Services	A 3-year outreach and education project to identify those in need, targeting homeless shelters and domestic violence service providers to help and counsel children who have experienced trauma .
Mariposa Women and Family Center	$ 238,898	Mariposa Children's Intervention Program (CHIP)	Use existing partnerships with local school districts, local community institutions, and low-income parents to provide programming to engage children and identify and treat mental health issues among children in Orange County.
NAMI Orange County	$ 546,380	Mental Health Education & Outreach	Offer evidence based programs such as Parent Connector, Basics Education, Progression, NAMI Connects at CHOC, and a quarterly Family Fun Event - 1K Awareness Walks for Families in collaboration with Family Resource Centers (FRC).
OC United	$ 901,500	Creating Capacity and Expanding Resilience for Children, Families, and their Communities	Expand current program engagement in local organizations, pilot a Whole-Child Treatment Team model, increase community resilience and engagement, reduce stigma, as well as increase accessibility to resources.
OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$ 685,000	The API Project HOPE	Provide mental health and wellness, culturally competent and linguistically appropriate services that include outreach and education to promote health awareness, support groups, educational trainings, resource referral and linkage, etc. Program will provide case management, in-home/community-based group counseling.

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Organization Name	Request ($)	Project Title	Project Description
Orange County Department of Education	$ 4,583,290	School-Based Student Wellness Centers	Pilot School-Based Student Wellness Centers (SWCs) within seven Orange County districts where all students can access support, resources and information on a variety of topics around mental health at their school site.
PADRES UNIDOS	$ 55,000	Early Learning Programs	Provide community-based modules such as Parents as Teachers/Early Education Modules where parents have identified that preschool-aged kids exhibit early signs of concerning behavior that can lead to future mental health challenges.
Radiant Health Centers	$ 450,000	Children's Mental Health Program Expansion	Provide outreach, community partnership building and outpatient mental health services with a focus on the subpopulations of children infected or affected by HIV and LGBTQ+ youth. The program will reduce stigma, increase awareness of mental health services and increase access to services.
Straight Talk Clinic, Inc.	$ 186,000	Children's Mental Health Support	Expand program with a pilot weekly on-site counseling services and comprehensive outreach series for children and families.
The Center for Autism & Neurodevelopmental Disorders	$ 743,672	Child Mental Health Cooperative (CMHC)	Expand child mental health services by delivering a consultative support program to providers, creating a unique interactive video-conferencing classroom and optimizing partnerships and collaborations.

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Organization Name	Request ($)	Project Title	Project Description
Vision y Compromiso	$ 875,235	Salud y Bienestar Para Todos	Collaborate with schools and community partners in Anaheim and Westminster to deliver evidence-based outreach and education strategies by engaging *promotores* to share information and resources.
Vista Community Clinic	$ 433,045	Providing School-Based Mental Health Services to La Habra Youth in Need	Project will designate 3-5 schools in La Habra as interim FQHC sites and assign three Licensed Clinical Social Workers to provide on-campus, 1-on-1 therapy to youth with mild to moderate behavioral health symptoms.
Wellness & Prevention Center	$ 153,951	Expansion of School and Community-based Youth Wellness Programming	Increase bilingual staff, support a coalition of Spanish-speaking parents and providers, and establish a presence at five new schools and community centers.
Women's Transitional Living Center, Inc.	$ 50,000	Children's Therapy Program	Counselors work with children through treatment plans that are age-appropriate, creative, and flexible, and can incorporate a range of counseling services, including individual counseling, family counseling, art therapy, sand therapy, and play therapy.

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RFP 2. Integrate Children's Mental Health Services Into Primary Care			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
AltaMed Health Services Corporation	$ 998,040	Integrating Children's Mental Health Into Primary Care in Orange County	Enhance current pediatric primary care services by integrating mental health services for children, providing referrals to early intervention, and engaging parents through community outreach and education.
CHOC Children's	$ 4,785,076	Expanding Mental Health Access and Knowledge in Pediatric Primary Care and Community Settings	Establish mental health screening, embedded mental health services, telehealth, and resource and referral for members in clinics served by CHOC Medical Group and in CHOC's Primary Care Network. Program will also provide trainings over the 3 years.
Families Together of Orange County	$ 920,000	Expanding Children's Mental Health Services	Integrate children's mental health services into primary care by offering on-site outpatient pediatric mental health care at the community health center in Tustin with outreach and education.
Friends of Family Health Center	$ 600,000	Healthy Steps	Introduce the evidence-based model HealthySteps program designed to have a specialist screen and provide families with support for common and complex concerns during a well-child visit. The HealthySteps specialist will assist with referrals and connects to additional services.
Laguna Beach Community Clinic	$ 69,109	Pediatric Mental Health: Screening and Case Management to Increase Access to Treatment	Provide screening, case management, and linkage to mental health resources and treatment for Cal-Optima members
Livingstone Community Development Corporation	$ 626,000	Integrating Children's Mental Health Services into Medical Care	Integrate outpatient mental health services into pediatric primary care screening and expand its arts and music therapy program.
Share Our Selves Corporation (SOS)	$ 200,000	Children's Mental Health Expansion Project	Expand SOS Children and Family Health Center's hours of operation from 40 to 45 hours per week and access to behavioral health outreach education and counseling services.

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IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 2,848,235	Child Psychiatry Consultation and Fellowship Program for Primary Care Providers (CPCFP)	Provide same day telephone consultation to PCPs by a child and adolescent psychiatrist in addition to rapid tele-video consult with ongoing education and training in mental health.
The Safety Net Foundation (FQHC Collaborative)	$ 2,496,000	Pediatric Integration of Behavioral Health in Primary Care for CalOptima's Safety Net: Expansion of Care Coordination, Mid-Level Provider Availability, Telehealth Options and Evidence-Based Training at Community Health Centers	Increase access to pediatric mental health care through the expansion of mid-level providers, the exploration of telemedicine and the integration of behavioral health with pediatric primary care.
Vista Community Clinic	$ 426,422	Enhancing Children's Mental Health via Primary Care Integration and Community Outreach in La Habra	A primary care - mental health integration project for Hispanic youth and their families living in and around the City of La Habra.

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IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

RFP 3. Increase Access to Medication-Assisted Treatment			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Ahura Healthcare	$ 2,850,000	Medicated-Assisted Treatment (MAT)	Provide comprehensive mental health and addiction medicine care with the use of Medicated-Assisted Treatment (MAT) therapy such as Suboxone, Methadone, and Naltrexone provided by licensed physicians along with mental health services and counseling.
Bright Heart Health	$ 3,915,000	Opioid Use Disorder OnDemand Treatment	Provide complete telehealth MAT services through Data2000 physicians, nurse practitioners, and physician assistants.
Central City Community Health Center	$ 930,000	CCCHC SUD-MAT Services & Educational Program	Expand access to and enhance existing, integrated and evidenced-based, SUD-MAT clinical care program with the City of Anaheim Health Center as the "hub" with services available via in-person provider or telehealth. The project includes providing service through mobile units.
Clean Path Recovery LLC	$ 5,998,484	Clean Path Recovery MAT Program	Program will use FDA approved medications in combination with counseling, holistic and behavioral therapies.

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IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
Coalition of Orange County Community Health Centers	$ 5,998,000	MATCONNECT: A County-wide Collaborative for MAT Expansion to CalOptima Members at Community Health Centers	Build capacity and expand access and delivery of MAT services by bridging integration gaps in the Substance Use Disorder (SUD) system of care in Orange County. Implement a localized version of the DHCS Hub and Spoke model and build internal capacity for increased MAT services and access for each of the Spoke locations.
Friends of Family Health Center	$ 600,000	Medication Assisted Treatment	Introduce Medication Assisted Treatment (MAT) with emphasis on opioid addiction with an individually tailored and extensive care coordination for patients
Livingstone Community Development Corporation	$ 808,000	Establishing a Substance Abuse Program with Medication-Assisted Treatment	Establish a new medication-assisted treatment (MAT) program which will be integrated with physical and behavioral health services and include supervised exercise and acupuncture treatments.
Serve the People	$ 1,485,000	Integrated Behavioral Health for Hard To Reach Populations	Purchase and staff Integrated Services (IS) Mobile Clinics and provide integrated whole-person care to individuals at the Courtyard and to others in addiction treatment facilities.
Share Our Selves Corporation (SOS)	$ 200,000	SOS Behavioral Health Expansion Project	Increase capacity to provide comprehensive behavioral health and case management services via telehealth technology and new medical/behavioral health mobile unit at homeless shelters operated by SOS's partner agencies throughout the county.

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Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 1,825,518	Establishing and Increasing the capacity of a Medication Assisted Treatment program through a Hub-and-Spoke model for CalOptima patients	Establish and expand the capacity of medication-assisted treatment (MAT) within Orange County. The hubs will be the Zephyr Medical Group in Laguna Hills and UC Irvine Medical Center.

RFP 4. Expand Mobile Food Distribution Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 250,000	OC Food Bank Mobile Food Trolley	Project will use OC Food Bank's mobile food trolley to provide a variety of food that is distributed on a first-come, first-served basis and may include items such as produce, non-perishable goods and protein.

RFP 5. Expand Access to Food Distribution Services Focused on Children and Families			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Global Operations & Development / Giving Children Hope	$ 50,000	We've Got Your Back (WGYB)	Food distribution program fills and distributes more than 1,100 backpacks of nutritious food including fruits and vegetables on a weekly basis.
LiveHealthy OC	$ 990,000	The LiveHeathy OC "Farmacy" Project - Establishing a Sustainable Farm to Clinic Network to Increase Access to Fresh, Healthy Foods for Underserved and Low Income Patients	Expands current access to fresh fruits and vegetables using a sustainable farm-to-clinic produce delivery system – the "farmacy" – at five community health centers through a monthly mobile farmers' market.
Livingstone Community Development Corporation	$ 300,000	Expanding Food Access for Children and Families	Expanding food pantry and integrate access to the food pantry into Group Medical Visits with CalOptima members suffering from diabetes, obesity, hypertension, and/or heart disease
Serve the People	$ 1,000,000	OC Food Oasis Partnership	Expand mobile food distribution to five FQHC sites and shelters that serve homeless persons. The strategy is to include healthy food and meal distribution, nutrition education, a 'food as medicine' prescription food box program for patients with chronic disease, and demonstrations on healthy food preparation and cooking, plus outreach and case management to services establishing a system to address social determinants of health.

Organization Name	Request ($)	Project Title	Project Description
Vista Community Clinic	$ 289,533	In the Kitchen: An Innovative Education/Food Distribution Program in La Habra	Develop a teaching kitchen that will provide nutrition education and hands-on cooking lessons to participants (accommodate groups of 12 residents).

RFP 6. Expand Access to Food Distribution Services for Older Adults			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 231,514	Farm-to Seniors Food Distribution Program	Provide fresh, healthy food to older adult CalOptima members through a network of 17 distribution sites.
Multi-Ethnic Collaborative of Community Agencies	$ 500,000	Increasing Food Access for Underserved Multi-Ethnic Older Adults	Expand food access distribution at the seven MECCA sites by building the volunteer base capacity, expand outreach, and provide culturally appropriate education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
18 Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize expenditures for CalOptima's participation in the following community events:
    a. Up to $10,000 and staff participation at the Vietnamese Community of Southern California (VNCSC) 2019 Year of the Rat Tet Festival in Fountain Valley on January 25-26, 2020;
    b. Up to $10,000 and staff participation at the Union of Vietnamese Student Associations Southern California (UVSA) 39th Annual Tet Festival Year of the Rat in Costa Mesa on January 25-26, 2020; and
    c. Up to $5,000 for CalOptima's participation in the Family Voices of California (FVCA) 2020 Annual Health Summit and Legislative Day on March 15-17, 2020 in Sacramento;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background
CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion
The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen relationships with our community partners.

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a. **Vietnamese Community of Southern California (VNCSC) 2020 Year of the Rat Tet Festival in Fountain Valley**.
Staff recommends the authorization of expenditures for participation in the Lunar New Year Tet Festival scheduled in Fountain Valley. This event celebrates the new lunar year and preserves the Vietnamese culture and traditions with the surrounding community. The event will provide CalOptima opportunities to interact with our Vietnamese members and other festival attendees and share information about CalOptima's programs and services. Vietnamese members comprise approximately eleven percent of CalOptima's total membership. CalOptima has participated in this event for six years. Staff recommends CalOptima's continued support for this event with a $10,000 financial commitment for 2020, which includes the following: One (1) 20x20 exhibitor booth in a prime location, two, three (3) 3' x 8' banner displays, twenty (20) mentions on stage, twenty-five (25) radio impressions, fifteen (15) television impressions, and full ad on ten thousand (10,000) fliers distributed throughout the OC and two (2) 8'x 8' back drop on Tet Festival stage. The event organizer anticipates more than 20,000 visitors throughout the day. This is an educational event that will allow staff to provide outreach and education to the Vietnamese community and serve members speaking one or more of CalOptima's threshold languages. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about all CalOptima's programs and services with this under-served and hard to reach population.

b. **The Union of Vietnamese Student Associations Southern California (UVSA) 39th Annual Year of the Rat Tet Festival in Costa Mesa.** Staff recommends the authorization of expenditures for participation in the Lunar New Year Tet Festival scheduled in Costa Mesa. This event celebrates the new lunar year and preserves the Vietnamese culture and traditions with the surrounding community. The event will provide CalOptima opportunities to interact with our Vietnamese members and other festival attendees and share information about CalOptima's programs and services. Vietnamese members comprise approximately eleven percent of CalOptima's total membership. CalOptima has participated in this event for thirteen years. Staff recommends CalOptima's continued support for this event with a $10,000 financial commitment for 2020, which includes the following: Five (5) minute speaking opportunity, one (1) 20x 20 exhibitor booth in a prime location, twenty (20) admission tickets, two (2) three day admission badges, one (1) banner display near the main entrance, logo link on event website for one (1) year, full page program color ad, pageant program full page ad, Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services.

c. **Family Voices of California (FVCA) 2020 Annual Health Summit and Legislative Day in Sacramento.** Staff recommends the authorization of expenditures for participation in FVCA's Annual Health Summit and Legislative Day scheduled in Sacramento. FVCA is a statewide collaborative of parent advocates focused on improving policies that ensure quality health care for children with special needs. FVCA also operates seven parent-run centers, providing information and support so families can make informed decisions about their children's health care. FVCA has been an influential advocacy organization working closely with DHCS and the Legislature on the Whole-Child Model program. Specifically, FVCA has

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reached out to Medi-Cal managed care plans, including CalOptima, to support Orange County children and families during the California Children's Services transition to the Whole-Child Model. CalOptima has participated in this event for three years. Staff recommends CalOptima's continued support for this event with a $5,000 financial commitment for 2020, which includes the following: Verbal recognition at the Summit, CalOptima logo on the Summit materials and social media, one (1) CalOptima branded item in attendee packets and Summit attendance for two (2) representatives.

CalOptima staff has reviewed the request and it meets the consideration for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $25,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness, and/or develop and strengthen partnerships in support of CalOptima's programs and services.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Board Action
2. Vietnamese Community of Southern California Sponsorship Request Letter
3. Union of Vietnamese Student Associations of So. California 2020 Tet Sponsorship Package
4. Family Voices of California 2020 Annual Health Summit Sponsorship Package

/s/ Michael Schrader — *11/26/2019*

Authorized Signature — **Date**

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Attachment to the December 5, 2019 Board of Directors Meeting – Agenda Item 18

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Vietnamese Community of Southern California	P.O. Box 457	Garden Grove	CA	92842-2316
Union of Vietnamese Student Associations of Southern California	P.O. Box 2069	Westminster	CA	92684
Family Voices of California	300 J. Street	Sacramento	CA	95814

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VIETNAMESE COMMUNITY OF SOUTHERN CALIFORNIA
CỘNG ĐỒNG VIỆT NAM NAM CALIFORNIA
DOMESTIC NON-PROFIT CORPORATION C1479500 • EIN 33-0448822 • FOUNDED 1990
P.O. BOX 457 • GARDEN GROVE, CA 92842-2316
EMAIL: CONTACT@VNCSC.ORG • WEBSITE: WWW.VNCSC.ORG
TEL (714) 248-6191

November 6th 2019

Dear Cal Optima,

We are writing you this letter concerning a sponsorship opportunity to celebrate the upcoming Lunar New Year 2020, the Year of the Rat.

Vietnamese Community of Southern California (VNCSC) has the honor of being selected to work with County of Orange and OC Park for the celebration of the 2020 OC Tet Festival at Mile Square Regional Park in Fountain Valley, from January 24th to January 26th 2020. This 3-day special event is free admission and open to public.

This is the fourth annual Tet Festival held at Mile Square Park, which, in past years, had attracted more than eighty thousands of Southern Californians and out-of-state visitors. This is a cost-effective opportunity to promote your business, and we would like to invite you to become one of our Major Gold Sponsors as last year.

A $10,000.00 sponsorship packages will provide you:
> 20’ x 20’ booth in prime location at the Tet Festival Mile Square Park
> Three (3) 3’ x 8’ banner displays
> Twenty (20) mentions on stage
> Twenty-five (25) radio impressions
> Fifteen (15) television impressions
> Full ad size 5.5 x 8 inches (the other side will be Tet Festival announcement) on ten thousand (10,000) flyers distributed throughout Orange County prior to the event.
> Two (2) 8’ x8’back drop on Tet Festival Stage.

For almost 30 years, the VNCSC has been a strong and influential voice for Little Saigon, the largest and most established community of Vietnamese expatriates in the world. With the collaboration of other non-profit organizations, we have provided resources to help our many members of the community at large and to preserve the Vietnamese Culture and Heritage.

The name and reputation of your business will not only be remembered by our patrons who came to the event, but also be known by their relatives and friends at home, too. The exposure of your company therefore would be significant and we cordially invite you to join our activities in order to reach out one of the most vibrant Vietnamese American Communities of the world and becomes a prestigious sponsor for the Vietnamese Cultural Village in this special event.

Your contribution can definitely make a difference and we are looking forward to building a successful partnership with your company. All any additional information, please feel free to contact us at:

Vietnamese Community of Southern California (VNCSC)
P.O. BOX 457, Garden Grove, CA 92842
Phone number: (714) 248-6191, Email: vncsc1990@gmail.com

Sincerely,

Hoa Nguyen

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TẾT

FESTIVAL
SPONSORSHIP PROPOSAL

JANUARY 24-26, 2020
OC FAIR & EVENT CENTER

Celebrating the Year of the Rat



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DEAR PROSPECTIVE SPONSOR,

The Union of Vietnamese Student Associations Southern California (UVSA) is proud to submit this proposal for your review. We wish to provide your organization with unique and advantageous marketing opportunities to promote your brand and business to our diverse audience.

The 39th Annual UVSA Tết Festival will take place between January 24 to 26, 2020 at OC Fair & Event Center — adjacent to Costa Mesa, Newport Beach, Santa Ana, and Irvine. The event attracts upwards to 50,000 guests, encompassing a multi-ethnic populace with strong Asian American presence.

The event is recognized as the most distinguished Vietnamese Lunar New Year celebration in the nation for many reasons:

- UVSA has hosted the largest Tết Festival in the nation with 38 continuous years of success
- UVSA is one of the four pillars upholding the Vietnamese community in cooperation with the Vietnamese American Federation of Southern California, the Coalition of Vietnamese Armed Forces, and the Association of Vietnamese Language & Culture Schools of Southern California
- We are the strongest Vietnamese youth organization in the country and we represent students and young professionals in the Santa Barbara, Los Angeles, Riverside, San Bernardino, and San Diego counties
- Our involvement in the community is built upon cultural awareness, education, and social and civic engagement
- We provide leadership opportunities to over 300 volunteers
- UVSA is a 501(c)(3) charitable organization and has awarded over $1,500,000 in festival proceeds to deserving non-profit organizations across Southern California

We cordially invite your team to join us this year in making UVSA Tết Festival the most spectacular yet! We look forward to building a partnership with you as we welcome the Year of the Rat with prosperity and success for all. Thank you for your consideration.

Sincerely,

Nguyen D. Nguyen
President
president@uvsa.org

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FESTIVAL SUMMARY

EVENT
39th Annual UVSA Tết Festival

DESCRIPTION
Tết is a celebration of the Lunar New Year, the most observed holiday for Vietnamese people

OBJECTIVES
1. To celebrate the new lunar year
2. To preserve and promote Vietnamese culture & traditions with the surrounding community
3. To provide opportunities for local businesses to promote their products and services
4. To raise funds to support educational and cultural programs in the community
5. To bring Vietnamese youths together and provide them with opportunities for leadership development and community service

DATES
Friday, January 24, 2020; 4PM - 10PM
Saturday, January 25, 2020; 11AM - 10PM
Sunday, January 26, 2020; 11AM - 9PM

LOCATION
OC Fair & Event Center
88 Fair Dr., Costa Mesa, CA 92626

ATTENDANCE
50,000+ guests



Lion dancers performing at the Saturday Opening Ceremony

ATTRACTIONS
Carnival games and rides
Three stages, each offering a variety of programming for all ages
Vietnamese cultural village with over 30,000 sq feet of exhibits and structures
Exhibit hall with over 100 unique vendors

PROGRAMS

Miss Vietnam Pageant	Opening Ceremony	Children's Contests
Pho Eating Contests	Talent Show	Dance Competition
Live Music & Karaoke	Youth Night	Grand Concert
Gaming Tournaments	Cultural Performances	Influencer Meet & Greet

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HOSTING ORGANIZATION

ABOUT The Union of Vietnamese Student Associations of Southern California (UVSA) is a 501(c)(3) non-profit, non-partisan, community-based organization founded in 1982 consisting of students, alumni, young professionals, and community leaders. Our mission is to bring together Vietnamese American students and young professionals across Southern California to build unity, to serve the community, and to advocate for social justice issues that affect our community domestically and in Vietnam.

GRANTS Each year, half of net profits from the event are allocated towards the Tết Community Assistance Fund. Over the past 15 years, UVSA has awarded over $1.5 million to help Southern California non-profit organizations initiate community enrichment programs.

MEMBERS UVSA was founded on volunteerism and continues to be a 100% volunteer-based organization. With over 50 year-round staff, 300 project staff, and 500 day-of volunteers, UVSA strives to equip each volunteer with skillsets that will help them excel in their professional careers. Additionally, UVSA partners with local, self-governing Vietnamese student associations from the following universities:

- Chapman
- Cal Poly Pomona
- CSU Fullerton
- CSU Long Beach
- CSU Northridge
- San Diego State
- UC Irvine
- UC Riverside
- UC Santa Barbara
- UC San Diego
- University of Southern California



DEMOGRAPHICS & STATISTICS

According to the 2018 U.S. Census, 1,548,449 people identify as Vietnamese, ranking them fourth among the Asian American groups; 447,032 (40%) of them live in California. The largest Vietnamese population outside of Vietnam is found in Southern California—totaling over 300,000 members from Los Angeles, Orange, and San Diego counties. Vietnamese American businesses continue to grow in areas such as Garden Grove and Westminster while rapidly extending lucrative development to surrounding cities.

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KEY BENEFITS

The success of this event depends on the generosity of sponsors. In return, UVSA aims to provide sponsor with the following benefits:

- Brand awareness and brand loyalty from current and prospective buyers
- High-level media exposure from local television stations, radio stations, magazines, newspapers, and advertisements
- Large-scale onsite product promotion and face-to-face customer interaction
- Positive public outreach and market response
- Recognition as an industry leader above competitors



Toyota showcases their latest vehicles in a custom 30' x 40' booth



The Miss Vietnam of Southern California Royal Court pose for Lexor's custom 20' x 10' booth



The Miss Vietnam of Southern California Royal Court pose for Sunpower's 20' x 20' booth

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SPONSOR PACKAGES

We offer the following sample packages which include standard benefits. However, we prefer to create for you a custom package designed to best connect your business to our audience. We hope that you take this opportunity to sponsor the event as a means to promote brand loyalty from a very accomplished community.

	SPONSOR BENEFITS	MEDIA OR IN-KIND TRADE (varies with value)	BRONZE $3,500	SILVER $6,000	GOLD $12,000	DIAMOND $20,000	TITLE $35,500
PRE-EVENT	Logo and link on event website for 1 year	✓	✓	✓	✓	✓	✓
	Social media post				✓	✓	✓
	Logo on event ad in Vietnamese newspapers					✓	✓
	Logo on all promotional materials						✓
	Logo on online admission tickets						✓
	Logo on event billboard in Garden Grove						✓
ON-SITE	Booth in prime location	10' x 10'	10' x 10'	10' x 20'	20' x 20'	20' x 30'	20' x 40'
	Admission tickets	30	10	20	40	90	150
	3-day admission badges	1	1	2	4	8	10
	3-day parking hang tags	1	1	2	4	8	10
	Banner display near main entrance	1	1	1	1	1	1
	Banner display near exit				1	6	1
	Banner display near main stage				1	2	4
	Graphic ad on main stage				3 runs / day	5 runs / day	5 runs / day
	Color ad on in event program book				half page	full page	back cover
	Logo on back of 500 volunteer t-shirts					✓	✓
	Logo on event directory					✓	✓
	30-second video ad on Main Stage						2 runs / day
	Speech at opening ceremony						5 minutes
	Speech at pageant with check presentation						5 minutes
	Sponsor mentions on PA system looped inside event entrance area						✓
	Logo on back of all admission tickets						✓

A LA CARTE BENEFITS

Admission Tickets — $6 ea
Admission Badges — $30 ea
Parking Hangtags (3-day) — $30 ea
Logo link on event website for 1 year — $500
Banner ad link on event website for 1 year — $750
Logo on back of 500 volunteer t-shirts — $500
Logo on event ad in newspapers — $1,000
Social media post — $250
Logo display on ticket booth windows — $400
Banner display (stage, gates, food court) — $500

On-site event activation with booth:
- 10' x 10' — $3,000
- 10' x 20' — $5,000
- 20' x 20' — $8,000
- 20' x 30' — $12,000
- 20' x 40' — $16,000

Program Book Ads (30,000 prints)
- Half-page color — $1,000
- Full page color — $1,500

Speaking opportunities — $1,000 (5 min)

Main Stage LED Screen Ads
- Graphic — $100 (1 run / day)
- 30-second video — $500 (1 run / day)

Presenting Sponsor for Programs:
- Pho Eating Contest — $1,500
- Children's Pageant — $1,500
- Talent Show — $1,500
- Youth Night — $3,000
- Grand Concert — $3,000

Pageant program full page ad — $1,000

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PLEDGE FORM

COMPANY NAME: _____

CONTACT NAME: _____ TITLE: _____

PHONE: ( ) _____ EMAIL: _____

SPONSORSHIP PACKAGE

- ☐ BRONZE ($3,500)
- ☐ SILVER ($6,000)
- ☐ GOLD ($12,000)
- ☐ DIAMOND ($20,000)
- ☐ TITLE ($35,500)
- ☐ MEDIA TRADE valued at: $ _____
- ☐ IN-KIND TRADE valued at: $ _____
- ☐ CUSTOM PACKAGE: $ _____
- ☐ DONATION ONLY: $ _____

PLEASE DESCRIBE ANY REQUESTS FOR YOUR SPONSORSHIP: _____

PLEASE DESCRIBE YOUR SERVICES: _____

_____ _____

SIGNATURE DATE

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UNION OF VIETNAMESE STUDENT ASSOCIATIONS OF SOUTHERN CALIFORNIA

"DEVELOPING THE NEXT GENERATION OF LEADERS"

CONTACT US

Tel: (714) 388-6711
Email: tet.sponsorship@uvsa.org

MAIL
PO BOX 2069
WESTMINSTER, CA 92684

WEBSITE
WWW.UVSA.ORG | WWW.TETFESTIVAL.ORG

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FAMILY VOICES of California

The voice of families
The vision of quality health care
The future for children and youth with special health care

Alpha Resource Center of Santa Barbara
4501 Cathedral Oaks Road
Santa Barbara, CA 93110
(805) 683-2145
info@alphasb.org

Eastern Los Angeles Family Resource Center
1000 South Fremont Ave.
Suite 6050, Unit 35
Alhambra, CA 91803
(626) 300-9171
info@elafrc.org

Family Resource Navigators
291 Estudillo Ave
San Leandro, CA 94577
(510) 547-7322
eileenc@frnoakland.org

Support for Families of Children with Disabilities
1663 Mission Street, Suite 700
San Francisco, CA 94103
(415) 282-7494
info@supportforfamilies.org

FAMILY VOICES OF CALIFORNIA
1663 Mission Street, Suite 700
San Francisco, CA 94103
(415) 282-7494

info@familyvoicesofca.org
www.familyvoicesofca.org

October 22, 2019

Tiffany Kaaiakamanu
Manager, Community Relations
CalOptima

Re: Sponsorship Request for Family Voices of CA 2020 Health Summit

Dear Tiffany:

Family Voices of California (FVCA) provides families of children and youth with special health care needs (CYSHCN) with information, tools, and support to advocate for better access to high quality care. We build partnerships, inform stakeholders, and foster parent engagement to give families a voice in healthcare policy making.

We would like to request sponsorship from CalOPtima for our 2020 Annual Health Summit and Legislative Day, which will be held on March 15-17, 2020 in Sacramento so that we may continue to advance these efforts. CalOPtima's sponsorship would specifically support family members from Orange County who are in the Whole Child Model program to attend the Summit. The funds will cover their travel, lodging, meals and a stipend for the 2 ½ days of meetings.

Advocates, health care providers and professionals, government representatives, and legislators and staff will join parents and caregivers for updates on health policy issues facing CYSHCN. Speakers will provide policy and program updates, and families will share perspectives on the impact of policies on their lives. The Summit will be followed by legislative meetings at the State Capitol, where families will educate lawmakers about the issues they face and put a personal face on the impact of legislation and budget decisions.

With your sponsorship we can make our 2020 Summit a great success by:

- Educating and informing parents and decision makers about critical issues facing CYSHCN.
- Building collaboration among families, legislators, regulators, providers, and community based organizations to increase parent involvement at all levels of community and government health policy making.
- Engaging parents in policymaking through legislative meetings.

Nearly 100% of those attending our 2019 Summit agreed that the support, information, and resources they received helped them feel more confident about getting their child the health care and services they need; and as a result they took action during Legislative Day and beyond. With your support FVCA can continue our work to advance public policies and system improvements that will help families of CYSHCN access the care they need.

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Please see the attached menu of sponsorship activities, and don't hesitate to contact me for more information at pipmarks@familyvoicesofca.org or 415-282-7494 ext. 123.

Thank you for your consideration of this request!

Sincerely,



Pip Marks
Project Director

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FAMILY VOICES of California

2020 Health Summit Sponsorship Commitment

March 15-17, 2020
Holiday Inn Sacramento – Capitol Plaza
300 J Street, Sacramento, CA 95814

Please return your completed form to Pip Marks at pipmarks@familyvoicesofca.org or 1663 Mission Street, Suite 700, San Francisco, CA 94103

☐ **Leadership – $10,000**

A speaking role at the Summit
Verbal recognition at the Summit
Prominently placed logo on Summit materials
Inclusion of 1 item in attendee packets
Inclusion in social media marketing
Summit attendance for 3 representatives

☐ **Spirit – $5,000**

Verbal recognition at the Summit
Logo on Summit materials
Inclusion in social media marketing
Inclusion of 1 item in attendee packets
Summit attendance for 2 representatives

☐ **Partner – $2,500**

Verbal recognition at the Summit
Logo on Summit materials
Summit attendance for 1 representative

☐ **Collaboration – $1,500**

Verbal recognition at the Summit
Listing in Summit materials
Summit attendance for 1 representative

☐ **Hope – $800 x _____ = $ _____** **(**Sponsor a family member to attend the Summit)

Listing in Summit materials

Sponsor a parent/caregiver of a child with special health care needs to attend the Summit. Each family sponsorship provides travel, lodging, and childcare.

☐ **Other – Donation**

Amount:

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FAMILY VOICES of California

2020 Health Summit Sponsorship Commitment

March 15-17, 2020
Holiday Inn Sacramento – Capitol Plaza
300 J Street, Sacramento, CA 95814

Please make checks payable to:
Support for Families of Children with Disabilities
and reference/memo Family Voices of California

Please return your completed form and send to:

Pip Marks at pipmarks@familyvoicesofca.org
or
1663 Mission Street, Suite 700, San Francisco, CA 94103

Name: _____

Organization/Company: _____

Address: _____

City _____ State _____ ZIP _____

Phone _____ Email _____

Thank you for your support of families of children and youth with special health care needs!

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Board of Directors Meeting
December 5, 2019

Provider Advisory Committee (PAC) Update

November 14, 2019 PAC Meeting

At the November 14, 2019 Provider Advisory Committee (PAC) meeting, Michael Schrader, Chief Executive Officer, updated the PAC on the Cal-AIM program. Mr. Schrader also updated the committee members on the Department of Health Care Services (DHCS) Managed Care Plans (MCP) state waiver proposal for 2021-2025. Mr. Schrader also notified the PAC of Nancy Huang's promotion to Chief Financial Officer.

David Ramirez, M.D., Chief Medical Officer, notified the PAC of the commendable rating received by CalOptima from the National Committee for Quality Assurance (NCQA) and notified the committee of the promotion of Emily Fonda, M.D. to Deputy Chief Medical Officer.

Jonathan T. Megerian, M.D., a board-certified Pediatric Neurologist at CHOC Children's, presented on the new Thompson Autism Center. This presentation solicited many questions from PAC members as Dr. Megerian described the benefits and services that will be offered once this state-of-the-art center has opened.

Ladan Khamseh, Chief Operating Officer, updated the committee members on the Qualified Medicare Beneficiary (QMB) Program and provided an overview of the QMB program. Ms. Khamseh noted that beneficiary outreach letters have been sent out to CalOptima members encouraging them to apply for Medicare Part A. Ms. Khamseh also notified the PAC of the recent vacancy of the Consumer seat on the Member Advisory Committee (MAC).

PAC received an informative presentation on the Health Network Quality Rating Methodology, a Proposition 56 (Tobacco Tax) verbal update and a Federal and State Legislative update.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide updates on the PAC's current activities.

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Board of Directors Meeting
December 5, 2019

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

At the October 24, 2019 OneCare Connect Member Advisory Committee (OCC MAC) meeting, Michael Schrader, Chief Executive Officer, updated the members on the draft 2020-22 Strategic Plan that is being finalized by Chapman Consulting. Mr. Schrader also updated the members on the Delivery System Model review that is also being undertaken by Pacific Health Consulting Group.

Ladan Khamseh, Chief Operating Officer, updated the members on the Qualified Medicare Beneficiary (QMB) Program and provided an overview of the QMB program that allows members to receive assistance from the State to pay their Medicare premiums. This program helps pay for Part A and Part B premiums, deductibles, coinsurance, and copayments.

OCC MAC received the following informational presentations:

David Ramirez, M.D., Chief Medical Officer, and Marie Jeannis, Enterprise Analytics Manager, presented an update on the Homeless Health Initiative that included data on visits from the various homeless areas where CalOptima members have been treated.

Member Sara Lee, Legal Aid Society of Orange County (LASOC), provided an Ombudsman Update, reporting that LASOC has incorporated dental benefits information for OCC members into LASOC's outreach and education presentation to OCC members.

Andrew Tse, Manager, OneCare Connect Customer Service, presented on the new OCC benefits for 2020. OCC MAC also received an informational Federal and State Legislative update from Shamiq Hussain, Sr. Policy Advisor, who reviewed several items on the legislative bill matrix that was provided to the members.

Chair Mouton formed an ad hoc committee that will review the OCC MAC seat descriptions and make recommendations to the recruitment workgroup made up of MAC, OCC MAC and PAC members to ensure that all members are being represented on each committee.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

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CALOPTIMA
BOARD OF DIRECTORS
PROVIDER NETWORK STRATEGY
PRELIMINARY FINDINGS
DECEMBER 5, 2019

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Prepared by Pacific Health Consulting Group and Milliman
December 5, 2019

Meeting Agenda

- Review Purpose of Consultation
- Scope of Work Project Approach
- Initial Findings
- Key Task Analysis and Recommendations to come
- Overall Network Strategy Approach
- Next Steps and Timeline

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Scope of Work

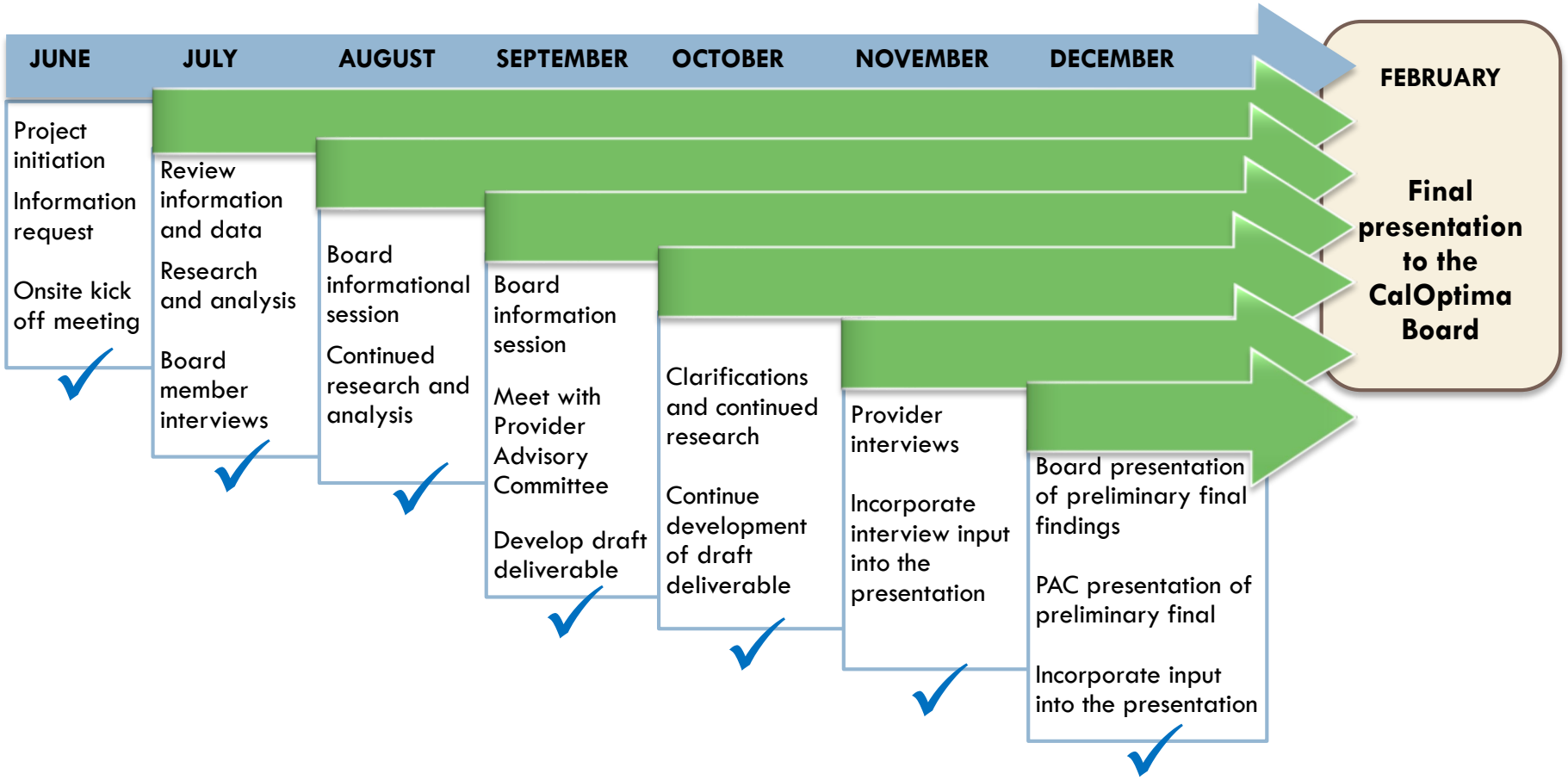
Provider network strategy analysis

RFP Task	Key Task	Slides
Added task	Board Interviews	
Added task	Board presentation: network payment models	
Added task	Board presentation: models to motivate network outcomes	
Added task	Provider Advisory Committee/provider interviews	
RFP Task 1	Review actuarial methodology	
RFP Task 2	Review Medical Loss Ratio (MLR) analysis	
RFP Task 3	Evaluate pre-contracting criteria	
RFP Task 4	Analyze membership limitation approach	
RFP Task 5	Evaluate auto assignment	
RFP Task 6	Research provider payment methodologies	
RFP Task 7	Develop network performance evaluation tool	
RFP Task 8	Research network models	
RFP Task 9	Analyze member satisfaction implications	
RFP Task 10	Analyze provider satisfaction implications	
RFP Task 11	Review administrative cost allocation model	
RFP Task 12	Analyze Health Needs Assessment	
	Final presentation	

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Project Approach

Structured project methodology and progress



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Initial Network Findings

High-level observations informed by multiple sources

- Multiple sources of information
  - Review CalOptima and Other Plans Policies and Procedures
  - CalOptima staff interviews (6/7)
  - Board of Directors (7/9, 8/1, 9/5)
  - Provider Advisory Committee (9/12)
  - Provider interviews (11/15, 11/22)
- Themes identified
  - Desire to be current in practices and policies
  - Increase transparency and accountability

- **High Level Observations**
  - CalOptima's networks incorporate leading practices in most areas
  - No major non-standard findings
  - Use of RFP unusual for Physician and Hospital Networks
  - Opportunities for improvement identified

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FINAL REPORT will compare CalOptima with best practices and provide recommendations

- Develop network goals and criteria for decision-making
- Default Policies
- Adding Providers/Contracts
- Terminate Providers/Contracts
- Establish Minimum/Maximum Guidelines
- Create network evaluation approach, including weighing measures
- Network neutral rate setting approach

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Report Organized Around Five Recommendations

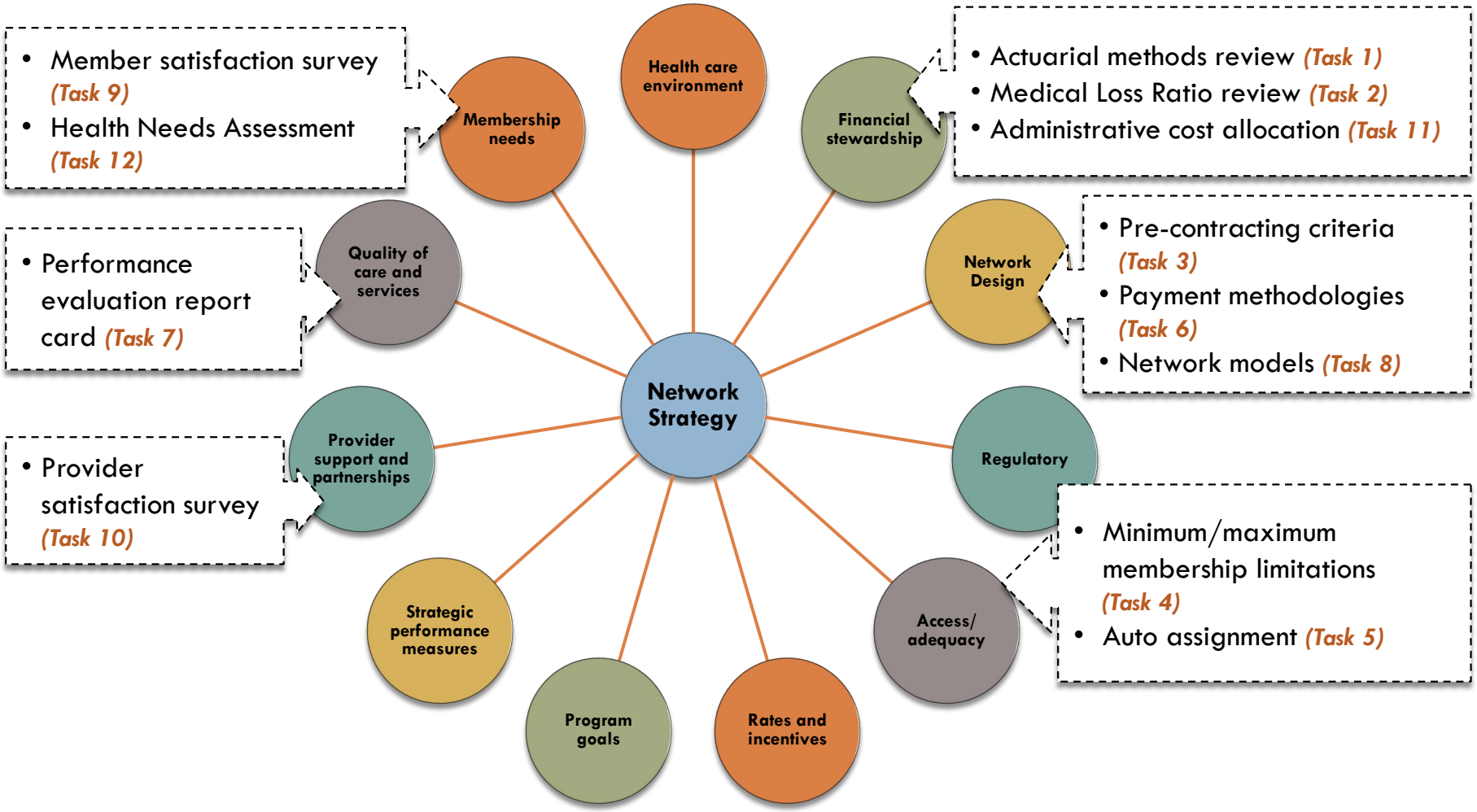
Opportunities for improvement

- **Begin with a CLEAR NETWORK VISION of CalOptima Board objectives for network access, adequacy, and cost and quality performance**
- **Create a comprehensive NETWORK STRATEGY that supports the CalOptima mission and vision with prioritized activities to meet network cost and performance goals**
- **IMPROVE EFFICIENCIES BY removing administrative efforts that aren't operating under clearly identify policies governing network contracting**
- **Add contracts to the provider network as needed to FILL HEALTH PLAN NEEDS, e.g. access, services, and specialties, and add any physician meeting criteria to the direct network**
- **INCREASE TRANSPARENCY AND ACCOUNTABILITY in network performance by reporting outcomes in relation to other networks with assistance to reach performance goals, particularly for essential service providers**

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Engagement Scope of Work

The scope of work focuses on selected components of a comprehensive network strategy



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Overall Recommendations to be made

- Develop Network Goals
- Translate Goals into Network Strategy
- Create Criteria for Networks to Meet
- Identify Policies and Procedures to be Approved by Board of Directors
- Transparent Approach Implemented by Staff and Regularly Reported to Provider Advisory Group and Board of Directors

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Next Steps and Timeline

- Incorporate Feedback from Provider Interviews
- Provider Advisory Committee Presentation
- Incorporate Feedback from Board and PAC Meetings
- Present Final Report February 6, 2020

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Caveats

This presentation is subject to the terms and conditions of the Consulting Services Agreement between CalOptima and Pacific Health Consulting Group (PHCG) dated May 7, 2019.

These slides are for discussion purposes only. They should not be relied upon without benefit of the discussion that accompanied them.

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Financial Summary

October 2019

Board of Directors Meeting

December 5, 2019

Nancy Huang

Chief Financial Officer

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FY 2019-20: Consolidated Enrollment

October 2019 MTD

Overall enrollment was 743,465 members

- Actual lower than budget 4,196 members or 0.6%
  - Medi-Cal unfavorable to budget 4,266 members or 0.6%
    - Medi-Cal Expansion (MCE) unfavorable variance of 4,613 members
    - Whole Child Model (WCM) unfavorable variance of 1,180 members
    - Seniors and Persons with Disabilities (SPD) favorable variance of 812 members
    - Temporary Assistance for Needy Families (TANF) favorable variance of 606
    - Long-Term Care (LTC) favorable variance of 109 members
  - OneCare Connect unfavorable to budget 2 members
  - OneCare favorable to budget 66 members or 4.4%
- 15,391 increase or 2.1% from September
    - Medi-Cal increase of 15,469 members due to prior year (PY) retroactive disenrollment adjustment recorded in September
    - OneCare Connect decrease of 93 members
    - OneCare increase of 3 members
    - PACE increase of 12 members

FY 2019-20: Consolidated Enrollment (cont.)

October 2019 YTD

Overall enrollment was 2,989,464 member months

- Actual lower than budget 11,486 members or 0.4%
  - Medi-Cal unfavorable to budget 11,705 members or 0.4%
    - MCE unfavorable variance of 11,747 members
    - WCM unfavorable variance of 4,276 members
    - SPD favorable variance of 3,074 members
    - TANF favorable variance of 1,146 members
    - LTC favorable variance of 98 members
  - OneCare Connect favorable to budget 4 members
  - OneCare favorable to budget 217 members or 3.6%
  - PACE unfavorable to budget 2 members or 0.1%

FY 2019-20: Consolidated Revenues

October 2019 MTD

- Actual higher than budget $13.6 million or 4.6%
  - ➢ Medi-Cal favorable to budget $13.1 million or 4.9%
    - Unfavorable volume variance of $1.6 million
    - Favorable price variance of $14.6 million
      - $12.0 million due to Department of Health Care Services (DHCS) year to date (YTD) acuity rate adjustment
  - ➢ OneCare Connect favorable to budget $366.4 thousand or 1.5%
    - Unfavorable volume variance of $3.4 thousand
    - Favorable price variance of $369.7 thousand
  - ➢ OneCare favorable to budget $147.4 thousand or 9.0%
    - Favorable volume variance of $71.9 thousand
    - Favorable price variance of $75.6 thousand
  - ➢ PACE favorable to budget $6.2 thousand or 0.2%
    - Favorable volume variance of $46.6 thousand
    - Unfavorable price variance of $40.4 thousand

FY 2019-20: Consolidated Revenues (cont.)

October 2019 YTD

- Actual higher than budget $119.6 million or 10.0%
  - ➢ Medi-Cal favorable to budget $116.3 million 10.8%
    - Unfavorable volume variance of $4.3 million
    - Favorable price variance of $120.6 million due to $104.3 million of directed payment (DP) revenue
      - $12.0 million due to DHCS acuity rate adjustment
  - ➢ OneCare Connect favorable to budget $2.6 million or 2.7%
    - Favorable volume variance of $6.7 thousand
    - Favorable price variance of $2.6 million
  - ➢ OneCare favorable to budget $737.7 thousand or 11.3%
    - Favorable volume variance of $236.2 thousand
    - Favorable price variance of $501.5 thousand
  - ➢ PACE unfavorable to budget $20.7 thousand or 0.2%
    - Unfavorable volume variance of $15.6 thousand
    - Unfavorable price variance of $5.1 thousand

FY 2019-20: Consolidated Medical Expenses

October 2019 MTD

- Actual higher than budget $16.1 million or 5.6%
  - ➢ Medi-Cal unfavorable variance of $15.1 million or 5.9%
    - Favorable volume variance of $1.5 million
    - Unfavorable price variance of $16.6 million
      - MLTSS expenses unfavorable variance of $7.9 million due to YTD true-up
      - Professional Claims unfavorable variance of $4.2 million
      - Provider Capitation expenses unfavorable variance of $2.9 million
      - Prescription Drugs unfavorable variance of $1.9 million
  - ➢ OneCare Connect unfavorable variance of $1.0 million or 4.4%
    - Favorable volume variance of $3.3 thousand
    - Unfavorable price variance of $1.0 million

FY 2019-20: Consolidated Medical Expenses (cont.)

October 2019 YTD

- Actual higher than budget $129.8 million or 11.5%
  - ➢ Medi-Cal unfavorable variance of $127.8 million or 12.5%
    - Favorable volume variance of $4.1 million
    - Unfavorable price variance of $131.9 million
      - Reinsurance and Other Expense category unfavorable variance of $97.9 million due to $104.0 million of DP, offset by favorable homeless health initiative
      - Professional Claims expenses unfavorable variance of $13.8 million
      - MLTSS expenses unfavorable variance of $8.9 million
      - Facilities expenses unfavorable variance of $7.3 million
  - ➢ OneCare Connect unfavorable variance of $2.6 million or 2.7%
    - Unfavorable volume variance of $6.6 thousand
    - Unfavorable price variance of $2.6 million

Medical Loss Ratio (MLR)

- October 2019 MTD: Actual: 96.8% Budget: 95.8%
- October 2019 YTD: Actual: 96.5% Budget: 95.2%

FY 2019-20: Consolidated Administrative Expenses

October 2019 MTD

- Actual lower than budget $2.0 million or 15.0%
  - Salaries, wages and benefits: favorable variance of $0.8 million
  - Other categories: favorable variance of $1.2 million

October 2019 YTD

- Actual lower than budget $8.0 million or 15.2%
  - Salaries, wages and benefits: favorable variance of $4.2 million
  - Other categories: favorable variance of $3.8 million

Administrative Loss Ratio (ALR)

- October 2019 MTD: Actual: 3.7% Budget: 4.5%
- October 2019 YTD: Actual: 3.4% Budget: 4.4%
  - Actual ALR (excluding DP revenue) is 3.7% MTD and 3.7% YTD

FY 2019-20: Change in Net Assets

October 2019 MTD

- $2.4 million change in net assets
- $2.2 million favorable to budget
  - Higher than budgeted revenue of $13.6 million
  - Higher than budgeted medical expenses of $16.1 million
  - Lower than budgeted administrative expenses of $2.0 million
  - Higher than budgeted investment and other income of $2.7 million

October 2019 YTD

- $15.1 million change in net assets
- $6.0 million favorable to budget
  - Higher than budgeted revenue of $119.6 million
  - Higher than budgeted medical expenses of $129.8 million
  - Lower than budgeted administrative expenses of $8.0 million
  - Higher than budgeted investment and other income of $8.3 million

Enrollment Summary: October 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
65,497	65,583	(86)	(0.1%)	Aged	261,432	261,542	(110)	(0.0%)
552	615	(63)	(10.2%)	BCCTP	2,182	2,460	(278)	(11.3%)
44,722	43,761	961	2.2%	Disabled	178,716	175,254	3,462	2.0%
284,334	283,444	890	0.3%	TANF Child	1,141,988	1,142,089	(101)	(0.0%)
86,367	86,651	(284)	(0.3%)	TANF Adult	350,763	349,516	1,247	0.4%
3,513	3,404	109	3.2%	LTC	13,714	13,616	98	0.7%
230,692	235,305	(4,613)	(2.0%)	MCE	928,949	940,696	(11,747)	(1.2%)
11,760	12,940	(1,180)	(9.1%)	WCM	47,484	51,760	(4,276)	(8.3%)
727,437	**731,703**	**(4,266)**	**(0.6%)**	**Medi-Cal Total**	**2,925,228**	**2,936,933**	**(11,705)**	**(0.4%)**
14,093	**14,095**	**(2)**	**(0.0%)**	**OneCare Connect**	**56,626**	**56,622**	**4**	**0.0%**
1,567	**1,501**	**66**	**4.4%**	**OneCare**	**6,206**	**5,989**	**217**	**3.6%**
368	**362**	**6**	**1.7%**	**PACE**	**1,404**	**1,406**	**(2)**	**(0.1%)**
743,465	**747,661**	**(4,196)**	**(0.6%)**	**CalOptima Total**	**2,989,464**	**3,000,950**	**(11,486)**	**(0.4%)**

Financial Highlights: October 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
743,465	747,661	(4,196)	(0.6%)	Member Months	2,989,464	3,000,950	(11,486)	(0.4%)
310,706,126	297,111,340	13,594,786	4.6%	Revenues	1,309,452,898	1,189,896,683	119,556,215	10.0%
300,785,441	284,705,333	(16,080,108)	(5.6%)	Medical Expenses	1,263,041,884	1,133,192,558	(129,849,326)	(11.5%)
11,428,798	13,452,357	2,023,559	15.0%	Administrative Expenses	44,614,097	52,582,584	7,968,487	15.2%
(1,508,113)	**(1,046,350)**	**(461,763)**	**(44.1%)**	**Operating Margin**	**1,796,916**	**4,121,541**	**(2,324,625)**	**(56.4%)**
3,902,328	1,250,000	2,652,328	212.2%	Non Operating Income (Loss)	13,284,850	5,000,000	8,284,850	165.7%
2,394,214	**203,650**	**2,190,565**	**1075.7%**	**Change in Net Assets**	**15,081,766**	**9,121,541**	**5,960,226**	**65.3%**
96.8%	95.8%	(1.0%)		Medical Loss Ratio	96.5%	95.2%	(1.2%)	
3.7%	4.5%	0.8%		Administrative Loss Ratio	3.4%	4.4%	1.0%	
(0.5%)	(0.4%)	(0.1%)		Operating Margin Ratio	0.1%	0.3%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		
3.7%	4.5%	0.8%		Administrative Loss Ratio (excluding Directed Payments)	3.7%	4.4%	0.7%	

*CalOptima updated the categorization of Directed Payments per Department of Healthcare Services instructions

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Consolidated Performance Actual vs. Budget: October 2019 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
0.4	0.6	(0.2)	Medi-Cal	5.3	9.9	(4.7)
(2.1)	(1.6)	(0.5)	OCC	(4.7)	(5.8)	1.0
0.1	(0.1)	0.2	OneCare	0.8	(0.5)	1.3
0.1	0.1	(0.0)	PACE	0.5	0.5	0.0
(1.5)	**(1.0)**	**(0.5)**	**Operating**	**1.8**	**4.1**	**(2.3)**
3.9	1.3	2.7	Inv./Rental Inc, MCO tax	13.3	5.0	8.3
3.9	**1.3**	**2.7**	**Non-Operating**	**13.3**	**5.0**	**8.3**
2.4	**0.2**	**2.2**	**TOTAL**	**15.1**	**9.1**	**6.0**

Consolidated Revenue & Expense: October 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	484,985	230,692	11,760	727,437	14,093	1,567	368	743,465
REVENUES								
Capitation Revenue	146,502,585	$ 111,943,759	$ 23,526,751	$ 281,973,095	$ 24,131,671	$ 1,781,586	$ 2,819,774	$ 310,706,126
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	146,502,585	111,943,759	23,526,751	281,973,095	24,131,671	1,781,586	2,819,774	310,706,126
MEDICAL EXPENSES								
Provider Capitation	38,678,383	44,728,700	12,529,063	95,936,145	11,187,103	476,579		107,599,828
Facilities	30,925,912	17,610,782	1,264,922	49,801,617	3,640,768	371,491	751,670	54,565,546
Ancillary	-	-	-	-	803,297	47,332	-	850,629
Professional Claims	23,310,364	4,492,440	(348,763)	27,454,041	-	-	595,103	28,049,144
Prescription Drugs	18,763,053	23,854,586	3,528,451	46,146,089	6,221,481	609,140	238,098	53,214,808
MLTSS	39,316,132	2,814,994	3,134,633	45,265,759	1,415,822	16,690	41,964	46,740,235
Medical Management	2,646,188	1,381,934	264,907	4,293,029	1,026,323	28,715	703,206	6,051,272
Quality Incentives	834,987	468,252	141,526	1,444,765	(9,285)		4,600	1,440,080
Reinsurance & Other	964,025	835,021	28,116	1,827,162	248,648		198,090	2,273,900
Total Medical Expenses	155,439,045	96,186,708	20,542,855	272,168,607	24,534,156	1,549,947	2,532,731	300,785,441
Medical Loss Ratio	106.1%	85.9%	87.3%	96.5%	101.7%	87.0%	89.8%	96.8%
GROSS MARGIN	**(8,936,460)**	**15,757,051**	**2,983,896**	**9,804,487**	**(402,485)**	**231,639**	**287,043**	**9,920,684**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,800,670	715,271	61,353	150,908	7,728,201
Professional fees				97,590	248,180	54,371	420	400,560
Purchased services				578,224	159,021	12,329	7,897	757,471
Printing & Postage				217,167	(8,640)	2,051	43,876	254,454
Depreciation & Amortization				365,300			2,092	367,392
Other expenses				1,492,623	30,927	654	4,893	1,529,096
Indirect cost allocation & Occupancy				(167,527)	519,792	35,589	3,770	391,624
Total Administrative Expenses				9,384,047	1,664,550	166,346	213,855	11,428,798
Admin Loss Ratio				3.3%	6.9%	9.3%	7.6%	3.7%
INCOME (LOSS) FROM OPERATIONS				420,441	(2,067,035)	65,293	73,187	(1,508,113)
INVESTMENT INCOME								3,911,094
TOTAL GRANT INCOME				(8,766)				(8,766)
CHANGE IN NET ASSETS				**$ 411,675**	**$ (2,067,035)**	**$ 65,293**	**$ 73,187**	**$ 2,394,214**
BUDGETED CHANGE IN NET ASSETS				596,644	(1,600,369)	(137,230)	94,605	203,650
VARIANCE TO BUDGET - FAV (UNFAV)				$ (184,969)	$ (466,666)	$ 202,523	$ (21,418)	$ 2,190,565

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Consolidated Revenue & Expense: October 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,948,795	928,949	47,484	2,925,228	56,626	6,206	1,404	2,989,464
REVENUES								
Capitation Revenue	634,927,254	$ 464,836,632	$ 93,581,020	$ 1,193,344,905	$ 97,935,487	$ 7,256,593	$ 10,915,913	$ 1,309,452,898
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	634,927,254	464,836,632	93,581,020	1,193,344,905	97,935,487	7,256,593	10,915,913	1,309,452,898
MEDICAL EXPENSES								
Provider Capitation	156,859,456	180,782,199	40,982,377	378,624,032	44,703,916	1,914,396		425,242,344
Facilities	101,028,571	86,147,871	12,802,390	199,978,832	14,704,556	1,510,475	2,852,736	219,046,599
Ancillary	-	-	-	-	2,764,537	178,450	-	2,942,987
Professional Claims	73,785,360	28,139,377	3,989,152	105,913,890	-	-	2,199,296	108,113,186
Prescription Drugs	70,878,717	85,528,648	22,065,842	178,473,206	22,871,579	2,125,151	890,662	204,360,598
MLTSS	140,053,606	11,036,755	5,977,415	157,067,776	5,571,420	39,246	134,306	162,812,747
Medical Management	8,725,852	4,797,010	1,042,997	14,565,859	4,158,399	147,023	2,753,770	21,625,051
Quality Incentives	3,372,523	1,883,782	566,375	5,822,680	812,055		17,912	6,652,647
Reinsurance & Other	63,766,483	46,748,898	101,064	110,616,444	753,606		875,675	112,245,725
Total Medical Expenses	618,470,568	445,064,540	87,527,611	1,151,062,719	96,340,069	5,914,741	9,724,356	1,263,041,884
Medical Loss Ratio	97.4%	95.7%	93.5%	96.5%	98.4%	81.5%	89.1%	96.5%
GROSS MARGIN	**16,456,686**	**19,772,092**	**6,053,409**	**42,282,186**	**1,595,418**	**1,341,852**	**1,191,557**	**46,411,013**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				25,449,195	2,829,499	227,222	561,745	29,067,662
Professional fees				682,192	432,524	99,371	889	1,214,976
Purchased services				2,989,906	708,866	66,516	46,165	3,811,453
Printing & Postage				1,025,900	173,704	16,488	44,609	1,260,701
Depreciation & Amortization				1,531,156			8,368	1,539,524
Other expenses				6,098,543	43,737	1,001	15,039	6,158,320
Indirect cost allocation & Occupancy				(765,769)	2,137,924	155,627	33,678	1,561,460
Total Administrative Expenses				37,011,124	6,326,254	566,226	710,494	44,614,097
Admin Loss Ratio				3.1%	6.5%	7.8%	6.5%	3.4%
INCOME (LOSS) FROM OPERATIONS				5,271,063	(4,730,836)	775,626	481,063	1,796,916
INVESTMENT INCOME								13,293,482
TOTAL GRANT INCOME				(8,766)				(8,766)
OTHER INCOME				135				135
CHANGE IN NET ASSETS				**$ 5,262,431**	**$ (4,730,836)**	**$ 775,626**	**$ 481,063**	**$ 15,081,766**
BUDGETED CHANGE IN NET ASSETS				9,948,071	(5,769,590)	(509,866)	452,926	9,121,541
VARIANCE TO BUDGET - FAV (UNFAV)				$ (4,685,640)	$ 1,038,754	$ 1,285,492	$ 28,137	$ 5,960,226

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Balance Sheet:
As of October 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$490,688,657	Accounts Payable	$5,908,235
Investments	452,003,433	Medical Claims liability	740,621,652
Capitation receivable	288,273,944	Accrued Payroll Liabilities	14,443,246
Receivables - Other	41,492,825	Deferred Revenue	39,591,614
Prepaid expenses	5,272,886	Deferred Lease Obligations	19,076
		Capitation and Withholds	154,489,926
Total Current Assets	**1,277,731,744**	**Total Current Liabilities**	**955,073,749**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	10,161,507		
505 City Parkway West	50,489,717		
	97,737,589		
Less: accumulated depreciation	(48,883,835)		
Capital assets, net	48,853,754	Other (than pensions) post employment benefits liability	25,208,920
Other Assets		Net Pension Liabilities	23,599,664
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,003,882,333**
Cash and Cash Equivalents	3,635,814		
Long-term Investments	562,103,130	**Deferred Inflows**	
Total Board-designated Assets	565,738,944	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	624,237,857	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**1,950,823,355**	TNE	105,737,627
		Funds in Excess of TNE	844,887,009
Deferred Outflows		**TOTAL NET POSITION**	950,624,636
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,961,913,804**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**1,961,913,804**

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Board Designated Reserve and TNE Analysis
As of October 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	155,076,251				
	Tier 1 - Logan Circle	153,868,433				
	Tier 1 - Wells Capital	154,335,289				
Board-designated Reserve		463,279,972	296,575,264	468,995,074	166,704,708	(5,715,102)
TNE Requirement	Tier 2 - Logan Circle	102,458,972	105,737,627	105,737,627	(3,278,655)	(3,278,655)
	Consolidated:	**565,738,944**	**402,312,891**	**574,732,701**	**163,426,053**	**(8,993,757)**
	Current reserve level	*1.97*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

October 2019

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CalOptima - Consolidated
Financial Highlights
For the Four Months Ended October 31, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
743,465	747,661	(4,196)	(0.6%)	Member Months	2,989,464	3,000,950	(11,486)	(0.4%)
310,706,126	297,111,340	13,594,786	4.6%	Revenues	1,309,452,898	1,189,896,683	119,556,215	10.0%
300,785,441	284,705,333	(16,080,108)	(5.6%)	Medical Expenses	1,263,041,884	1,133,192,558	(129,849,326)	(11.5%)
11,428,798	13,452,357	2,023,559	15.0%	Administrative Expenses	44,614,097	52,582,584	7,968,487	15.2%
(1,508,113)	**(1,046,350)**	**(461,763)**	**(44.1%)**	**Operating Margin**	**1,796,916**	**4,121,541**	**(2,324,625)**	**(56.4%)**
3,902,328	1,250,000	2,652,328	212.2%	Non Operating Income (Loss)	13,284,850	5,000,000	8,284,850	165.7%
2,394,214	**203,650**	**2,190,565**	**1075.7%**	**Change in Net Assets**	**15,081,766**	**9,121,541**	**5,960,226**	**65.3%**
96.8%	95.8%	(1.0%)		Medical Loss Ratio	96.5%	95.2%	(1.2%)	
3.7%	4.5%	0.8%		Administrative Loss Ratio	3.4%	4.4%	1.0%	
(0.5%)	(0.4%)	(0.1%)		Operating Margin Ratio	0.1%	0.3%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		
3.7%	4.5%	0.8%		Administrative Loss Ratio (excluding Directed Payments)*	3.7%	4.4%	0.7%	

*CalOptima updated the categorization of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Four Months Ended October 31, 2019

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	727,437	731,703	(4,266)	(0.6%)
OneCare Connect	14,093	14,095	(2)	(0.0%)
OneCare	1,567	1,501	66	4.4%
PACE	368	362	6	1.7%
Total	743,465	747,661	(4,196)	(0.6%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 412	$ 597	$ (185)	(31.0%)
OneCare Connect	(2,067)	(1,600)	(467)	(29.2%)
OneCare	65	(137)	203	147.4%
PACE	73	95	(21)	(23.2%)
505 Bldg.	-	-	-	0.0%
Investment Income & Other	3,911	1,250	2,661	212.9%
Total	$ 2,394	$ 204	$ 2,191	1073.5%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.5%	95.6%	(0.9)
OneCare Connect	101.7%	98.9%	(2.8)
OneCare	87.0%	99.2%	12.2

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,384	$ 11,251	$ 1,867	16.6%
OneCare Connect	1,665	1,861	196	10.5%
OneCare	166	150	(16)	(11.0%)
PACE	214	191	(23)	(12.2%)
Total	$ 11,429	$ 13,452	$ 2,024	15.0%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	963	1,145	182
OneCare Connect	173	200	26
OneCare	9	9	1
PACE	71	93	22
Total	1,216	1,447	231

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	755	639	116
OneCare Connect	81	71	11
OneCare	179	161	18
PACE	5	4	1
Total	1,020	875	146

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	2,925,228	2,936,933	(11,705)	(0.4%)
OneCare Connect	56,626	56,622	4	0.0%
OneCare	6,206	5,989	217	3.6%
PACE	1,404	1,406	(2)	(0.1%)
Total	2,989,464	3,000,950	(11,486)	(0.4%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 5,262	$ 9,948	$ (4,686)	(47.1%)
OneCare Connect	(4,731)	(5,770)	1,039	18.0%
OneCare	776	(510)	1,285	252.2%
PACE	481	453	28	6.2%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	13,294	5,000	8,294	165.9%
Total	$ 15,082	$ 9,122	$ 5,960	65.3%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.5%	95.0%	(1.5)
OneCare Connect	98.4%	98.3%	(0.0)
OneCare	81.5%	98.7%	17.2

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 37,011	$ 43,885	$ 6,874	15.7%
OneCare Connect	6,326	7,359	1,033	14.0%
OneCare	566	594	27	4.6%
PACE	710	744	34	4.6%
Total	$ 44,614	$ 52,583	$ 7,968	15.2%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	3,773	4,582	809
OneCare Connect	718	799	81
OneCare	30	37	7
PACE	284	366	82
Total	4,805	5,784	979

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	775	641	134
OneCare Connect	79	71	8
OneCare	207	161	46
PACE	5	4	1
Total	1,066	877	190

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended October 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	743,465		747,661		(4,196)	
REVENUE						
Medi-Cal	$ 281,973,095	$ 387.63	$ 268,898,321	$ 367.50	$ 13,074,774	$ 20.13
OneCare Connect	24,131,671	1,712.32	23,765,312	1,686.08	366,359	26.24
OneCare	1,781,586	1,136.94	1,634,176	1,088.72	147,410	48.22
PACE	2,819,774	7,662.43	2,813,531	7,772.19	6,243	(109.76)
Total Operating Revenue	310,706,126	417.92	297,111,340	397.39	13,594,786	20.53
MEDICAL EXPENSES						
Medi-Cal	272,168,607	374.15	257,050,419	351.30	(15,118,188)	(22.85)
OneCare Connect	24,534,156	1,740.88	23,505,039	1,667.62	(1,029,117)	(73.26)
OneCare	1,549,947	989.12	1,621,514	1,080.29	71,567	91.17
PACE	2,532,731	6,882.42	2,528,361	6,984.42	(4,370)	102.00
Total Medical Expenses	300,785,441	404.57	284,705,333	380.79	(16,080,108)	(23.78)
GROSS MARGIN	9,920,684	13.35	12,406,007	16.60	(2,485,322)	(3.25)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,728,201	10.39	8,562,474	11.45	834,273	1.06
Professional fees	400,560	0.54	492,718	0.66	92,158	0.12
Purchased services	757,471	1.02	1,233,276	1.65	475,805	0.63
Printing & Postage	254,454	0.34	565,630	0.76	311,176	0.42
Depreciation & Amortization	367,392	0.49	457,866	0.61	90,474	0.12
Other expenses	1,529,096	2.06	1,756,526	2.35	227,430	0.29
Indirect cost allocation & Occupancy expense	391,624	0.53	383,867	0.51	(7,757)	(0.02)
Total Administrative Expenses	11,428,798	15.37	13,452,357	17.99	2,023,559	2.62
INCOME (LOSS) FROM OPERATIONS	(1,508,113)	(2.03)	(1,046,350)	(1.40)	(461,763)	(0.63)
INVESTMENT INCOME						
Interest income	2,856,121	3.84	1,250,000	1.67	1,606,121	2.17
Realized gain/(loss) on investments	119,335	0.16	-	-	119,335	0.16
Unrealized gain/(loss) on investments	935,637	1.26	-	-	935,637	1.26
Total Investment Income	3,911,094	5.26	1,250,000	1.67	2,661,094	3.59
TOTAL GRANT INCOME	(8,766)	(0.01)	-	-	(8,766)	(0.01)
CHANGE IN NET ASSETS	**2,394,214**	**3.22**	**203,650**	**0.27**	**2,190,565**	**2.95**
MEDICAL LOSS RATIO	**96.8%**		**95.8%**		**-1.0%**	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**4.5%**		**0.8%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	2,989,464		3,000,950		(11,486)	
REVENUE						
Medi-Cal	$ 1,193,344,905	$ 407.95	$ 1,077,076,632	$ 366.74	$ 116,268,273	$ 41.21
OneCare Connect	97,935,487	1,729.51	95,364,583	1,684.26	2,570,904	45.25
OneCare	7,256,593	1,169.29	6,518,874	1,088.47	737,719	80.82
PACE	10,915,913	7,774.87	10,936,594	7,778.52	(20,681)	(3.65)
Total Operating Revenue	1,309,452,898	438.02	1,189,896,683	396.51	119,556,215	41.51
MEDICAL EXPENSES						
Medi-Cal	1,151,062,719	393.50	1,023,243,271	348.41	(127,819,448)	(45.09)
OneCare Connect	96,340,069	1,701.34	93,774,912	1,656.19	(2,565,157)	(45.15)
OneCare	5,914,741	953.07	6,435,186	1,074.50	520,445	121.43
PACE	9,724,356	6,926.18	9,739,189	6,926.88	14,833	0.70
Total Medical Expenses	1,263,041,884	422.50	1,133,192,558	377.61	(129,849,326)	(44.89)
GROSS MARGIN	46,411,013	15.52	56,704,125	18.90	(10,293,111)	(3.38)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	29,067,662	9.72	33,217,789	11.07	4,150,127	1.35
Professional fees	1,214,976	0.41	1,872,289	0.62	657,313	0.21
Purchased services	3,811,453	1.27	4,933,104	1.64	1,121,651	0.37
Printing & Postage	1,260,701	0.42	2,262,863	0.75	1,002,162	0.33
Depreciation & Amortization	1,539,524	0.51	1,831,464	0.61	291,940	0.10
Other expenses	6,158,320	2.06	6,923,481	2.31	765,161	0.25
Indirect cost allocation & Occupancy expense	1,561,460	0.52	1,541,594	0.51	(19,866)	(0.01)
Total Administrative Expenses	44,614,097	14.92	52,582,584	17.52	7,968,487	2.60
INCOME (LOSS) FROM OPERATIONS	1,796,916	0.60	4,121,541	1.37	(2,324,625)	(0.77)
INVESTMENT INCOME						
Interest income	11,750,208	3.93	5,000,000	1.67	6,750,208	2.26
Realized gain/(loss) on investments	921,675	0.31	-	-	921,675	0.31
Unrealized gain/(loss) on investments	621,599	0.21	-	-	621,599	0.21
Total Investment Income	13,293,482	4.45	5,000,000	1.67	8,293,482	2.78
TOTAL GRANT INCOME	(8,766)	-	-	-	(8,766)	-
OTHER INCOME	135	-	-	-	135	-
CHANGE IN NET ASSETS	**15,081,766**	**5.04**	**9,121,541**	**3.04**	**5,960,226**	**2.00**
MEDICAL LOSS RATIO	**96.5%**		**95.2%**		**-1.2%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.4%**		**1.0%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended October 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	484,985	230,692	11,760	727,437	14,093	1,567	368	743,465
REVENUES								
Capitation Revenue	146,502,585	$ 111,943,759	$ 23,526,751	$ 281,973,095	$ 24,131,671	$ 1,781,586	$ 2,819,774	$ 310,706,126
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	146,502,585	111,943,759	23,526,751	281,973,095	24,131,671	1,781,586	2,819,774	310,706,126
MEDICAL EXPENSES								
Provider Capitation	38,678,383	44,728,700	12,529,063	95,936,145	11,187,103	476,579		107,599,828
Facilities	30,925,912	17,610,782	1,264,922	49,801,617	3,640,768	371,491	751,670	54,565,546
Ancillary	-	-	-	-	803,297	47,332	-	850,629
Professional Claims	23,310,364	4,492,440	(348,763)	27,454,041	-	-	595,103	28,049,144
Prescription Drugs	18,763,053	23,854,586	3,528,451	46,146,089	6,221,481	609,140	238,098	53,214,808
MLTSS	39,316,132	2,814,994	3,134,633	45,265,759	1,415,822	16,690	41,964	46,740,235
Medical Management	2,646,188	1,381,934	264,907	4,293,029	1,026,323	28,715	703,206	6,051,272
Quality Incentives	834,987	468,252	141,526	1,444,765	(9,285)		4,600	1,440,080
Reinsurance & Other	964,025	835,021	28,116	1,827,162	248,648		198,090	2,273,900
Total Medical Expenses	155,439,045	96,186,708	20,542,855	272,168,607	24,534,156	1,549,947	2,532,731	300,785,441
Medical Loss Ratio	106.1%	85.9%	87.3%	96.5%	101.7%	87.0%	89.8%	96.8%
GROSS MARGIN	**(8,936,460)**	**15,757,051**	**2,983,896**	**9,804,487**	**(402,485)**	**231,639**	**287,043**	**9,920,684**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,800,670	715,271	61,353	150,908	7,728,201
Professional fees				97,590	248,180	54,371	420	400,560
Purchased services				578,224	159,021	12,329	7,897	757,471
Printing & Postage				217,167	(8,640)	2,051	43,876	254,454
Depreciation & Amortization				365,300			2,092	367,392
Other expenses				1,492,623	30,927	654	4,893	1,529,096
Indirect cost allocation & Occupancy				(167,527)	519,792	35,589	3,770	391,624
Total Administrative Expenses				9,384,047	1,664,550	166,346	213,855	11,428,798
Admin Loss Ratio				3.3%	6.9%	9.3%	7.6%	3.7%
INCOME (LOSS) FROM OPERATIONS				420,441	(2,067,035)	65,293	73,187	(1,508,113)
INVESTMENT INCOME								3,911,094
TOTAL GRANT INCOME				(8,766)				(8,766)
CHANGE IN NET ASSETS				**$ 411,675**	**$ (2,067,035)**	**$ 65,293**	**$ 73,187**	**$ 2,394,214**
BUDGETED CHANGE IN NET ASSETS				596,644	(1,600,369)	(137,230)	94,605	203,650
VARIANCE TO BUDGET - FAV (UNFAV)				$ (184,969)	$ (466,666)	$ 202,523	$ (21,418)	$ 2,190,565

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Four Months Ended October 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,948,795	928,949	47,484	2,925,228	56,626	6,206	1,404	2,989,464
REVENUES								
Capitation Revenue	634,927,254	$ 464,836,632	$ 93,581,020	$ 1,193,344,905	$ 97,935,487	$ 7,256,593	$ 10,915,913	$ 1,309,452,898
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	634,927,254	464,836,632	93,581,020	1,193,344,905	97,935,487	7,256,593	10,915,913	1,309,452,898
MEDICAL EXPENSES								
Provider Capitation	156,859,456	180,782,199	40,982,377	378,624,032	44,703,916	1,914,396		425,242,344
Facilities	101,028,571	86,147,871	12,802,390	199,978,832	14,704,556	1,510,475	2,852,736	219,046,599
Ancillary	-	-	-	-	2,764,537	178,450	-	2,942,987
Professional Claims	73,785,360	28,139,377	3,989,152	105,913,890	-	-	2,199,296	108,113,186
Prescription Drugs	70,878,717	85,528,648	22,065,842	178,473,206	22,871,579	2,125,151	890,662	204,360,598
MLTSS	140,053,606	11,036,755	5,977,415	157,067,776	5,571,420	39,246	134,306	162,812,747
Medical Management	8,725,852	4,797,010	1,042,997	14,565,859	4,158,399	147,023	2,753,770	21,625,051
Quality Incentives	3,372,523	1,883,782	566,375	5,822,680	812,055		17,912	6,652,647
Reinsurance & Other	63,766,483	46,748,898	101,064	110,616,444	753,606		875,675	112,245,725
Total Medical Expenses	618,470,568	445,064,540	87,527,611	1,151,062,719	96,340,069	5,914,741	9,724,356	1,263,041,884
Medical Loss Ratio	97.4%	95.7%	93.5%	96.5%	98.4%	81.5%	89.1%	96.5%
GROSS MARGIN	**16,456,686**	**19,772,092**	**6,053,409**	**42,282,186**	**1,595,418**	**1,341,852**	**1,191,557**	**46,411,013**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				25,449,195	2,829,499	227,222	561,745	29,067,662
Professional fees				682,192	432,524	99,371	889	1,214,976
Purchased services				2,989,906	708,866	66,516	46,165	3,811,453
Printing & Postage				1,025,900	173,704	16,488	44,609	1,260,701
Depreciation & Amortization				1,531,156			8,368	1,539,524
Other expenses				6,098,543	43,737	1,001	15,039	6,158,320
Indirect cost allocation & Occupancy				(765,769)	2,137,924	155,627	33,678	1,561,460
Total Administrative Expenses				37,011,124	6,326,254	566,226	710,494	44,614,097
Admin Loss Ratio				3.1%	6.5%	7.8%	6.5%	3.4%
INCOME (LOSS) FROM OPERATIONS				5,271,063	(4,730,836)	775,626	481,063	1,796,916
INVESTMENT INCOME								13,293,482
TOTAL GRANT INCOME				(8,766)				(8,766)
OTHER INCOME				135				135
CHANGE IN NET ASSETS				**$ 5,262,431**	**$ (4,730,836)**	**$ 775,626**	**$ 481,063**	**$ 15,081,766**
BUDGETED CHANGE IN NET ASSETS				9,948,071	(5,769,590)	(509,866)	452,926	9,121,541
VARIANCE TO BUDGET - FAV (UNFAV)				$ (4,685,640)	$ 1,038,754	$ 1,285,492	$ 28,137	$ 5,960,226

October 31, 2019 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $2.4 million, $2.2 million favorable to budget
- Operating deficit is $1.5 million, with a surplus in non-operating income of $3.9 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $15.1 million, $6.0 million favorable to budget
- Operating surplus is $1.8 million, with a surplus in non-operating income of $13.3 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
0.4	0.6	(0.2)	Medi-Cal	5.3	9.9	(4.7)
(2.1)	(1.6)	(0.5)	OCC	(4.7)	(5.8)	1.0
0.1	(0.1)	0.2	OneCare	0.8	(0.5)	1.3
0.1	0.1	(0.0)	PACE	0.5	0.5	0.0
(1.5)	**(1.0)**	**(0.5)**	**Operating**	**1.8**	**4.1**	**(2.3)**
3.9	1.3	2.7	Inv./Rental Inc, MCO tax	13.3	5.0	8.3
3.9	**1.3**	**2.7**	**Non-Operating**	**13.3**	**5.0**	**8.3**
2.4	**0.2**	**2.2**	**TOTAL**	**15.1**	**9.1**	**6.0**

CalOptima - Consolidated
Enrollment Summary
For the Four Months Ended October 31, 2019

Month-to-Date					Year-to-Date			
		$	%				$	%
Actual	Budget	Variance	Variance	Enrollment (by Aid Category)	Actual	Budget	Variance	Variance
65,497	65,583	(86)	(0.1%)	Aged	261,432	261,542	(110)	(0.0%)
552	615	(63)	(10.2%)	BCCTP	2,182	2,460	(278)	(11.3%)
44,722	43,761	961	2.2%	Disabled	178,716	175,254	3,462	2.0%
284,334	283,444	890	0.3%	TANF Child	1,141,988	1,142,089	(101)	(0.0%)
86,367	86,651	(284)	(0.3%)	TANF Adult	350,763	349,516	1,247	0.4%
3,513	3,404	109	3.2%	LTC	13,714	13,616	98	0.7%
230,692	235,305	(4,613)	(2.0%)	MCE	928,949	940,696	(11,747)	(1.2%)
11,760	12,940	(1,180)	(9.1%)	WCM	47,484	51,760	(4,276)	(8.3%)
727,437	**731,703**	**(4,266)**	**(0.6%)**	**Medi-Cal Total**	**2,925,228**	**2,936,933**	**(11,705)**	**(0.4%)**
14,093	**14,095**	**(2)**	**(0.0%)**	**OneCare Connect**	**56,626**	**56,622**	**4**	**0.0%**
1,567	**1,501**	**66**	**4.4%**	**OneCare**	**6,206**	**5,989**	**217**	**3.6%**
368	**362**	**6**	**1.7%**	**PACE**	**1,404**	**1,406**	**(2)**	**(0.1%)**
743,465	**747,661**	**(4,196)**	**(0.6%)**	**CalOptima Total**	**2,989,464**	**3,000,950**	**(11,486)**	**(0.4%)**
				Enrollment (by Network)				
161,655	162,333	(678)	(0.4%)	HMO	648,983	651,450	(2,467)	(0.4%)
208,410	209,470	(1,060)	(0.5%)	PHC	837,195	842,148	(4,953)	(0.6%)
181,034	187,480	(6,446)	(3.4%)	Shared Risk Group	736,969	752,777	(15,808)	(2.1%)
176,338	172,420	3,918	2.3%	Fee for Service	702,081	690,558	11,523	1.7%
727,437	**731,703**	**(4,266)**	**(0.6%)**	**Medi-Cal Total**	**2,925,228**	**2,936,933**	**(11,705)**	**(0.4%)**
14,093	**14,095**	**(2)**	**(0.0%)**	**OneCare Connect**	**56,626**	**56,622**	**4**	**0.0%**
1,567	**1,501**	**66**	**4.4%**	**OneCare**	**6,206**	**5,989**	**217**	**3.6%**
368	**362**	**6**	**1.7%**	**PACE**	**1,404**	**1,406**	**(2)**	**(0.1%)**
743,465	**747,661**	**(4,196)**	**(0.6%)**	**CalOptima Total**	**2,989,464**	**3,000,950**	**(11,486)**	**(0.4%)**

CalOptima - Consolidated
Enrollment Trend by Network Type
Fiscal Year 2020

Network Type	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	MMs
HMO													
Aged	3,723	3,740	3,754	3,821									15,038
BCCTP	1	1	2	2									6
Disabled	6,539	6,547	6,572	6,613									26,271
TANF Child	54,046	53,703	52,620	53,069									213,438
TANF Adult	27,944	27,740	27,446	27,279									110,409
LTC	2	1	3	3									9
MCE	68,973	69,077	68,729	68,881									275,660
WCM	2,026	2,087	2,052	1,987									8,152
	163,254	**162,896**	**161,178**	**161,655**									**648,983**
PHC													
Aged	1,548	1,540	1,524	1,542									6,154
BCCTP	-	-	-	-									-
Disabled	5,416	5,499	5,323	5,425									21,663
TANF Child	148,665	148,131	143,994	146,390									587,180
TANF Adult	11,149	11,322	10,925	10,865									44,261
LTC	-	-	1	-									1
MCE	37,510	37,479	37,084	37,037									149,110
WCM	7,209	7,276	7,190	7,151									28,826
	211,497	**211,247**	**206,041**	**208,410**									**837,195**
Shared Risk Group													
Aged	3,569	3,523	3,470	3,501									14,063
BCCTP	-	-	-	-									-
Disabled	7,275	7,294	7,144	7,177									28,890
TANF Child	63,291	62,381	57,001	59,579									242,252
TANF Adult	28,681	28,390	27,842	27,428									112,341
LTC	1	3	3	2									9
MCE	84,595	83,922	82,492	81,749									332,758
WCM	1,732	1,706	1,620	1,598									6,656
	189,144	**187,219**	**179,572**	**181,034**									**736,969**
Fee for Service (Dual)													
Aged	51,730	52,454	52,097	52,050									208,331
BCCTP	15	18	17	18									68
Disabled	20,752	20,053	20,586	20,577									81,968
TANF Child	-	19	1	1									21
TANF Adult	964	1,923	949	941									4,777
LTC	3,044	3,097	3,061	3,161									12,363
MCE	2,116	2,171	1,935	1,717									7,939
WCM	15	15	15	16									61
	78,636	**79,750**	**78,661**	**78,481**									**315,528**
Fee for Service (Non-Dual)													
Aged	4,682	4,211	4,370	4,583									17,846
BCCTP	550	542	484	532									2,108
Disabled	4,928	5,692	4,374	4,930									19,924
TANF Child	25,571	32,106	16,125	25,295									99,097
TANF Adult	19,658	19,951	19,512	19,854									78,975
LTC	328	326	331	347									1,332
MCE	40,680	41,152	40,342	41,308									163,482
WCM	843	960	978	1,008									3,789
	97,240	**104,940**	**86,516**	**97,857**									**386,553**
MEDI-CAL TOTAL													
Aged	65,252	65,468	65,215	65,497									261,432
BCCTP	566	561	503	552									2,182
Disabled	44,910	45,085	43,999	44,722									178,716
TANF Child	291,573	296,340	269,741	284,334									1,141,988
TANF Adult	88,396	89,326	86,674	86,367									350,763
LTC	3,375	3,427	3,399	3,513									13,714
MCE	233,874	233,801	230,582	230,692									928,949
WCM	11,825	12,044	11,855	11,760									47,484
	739,771	**746,052**	**711,968**	**727,437**									**2,925,228**
OneCare Connect	14,257	14,090	14,186	14,093									56,626
OneCare	1,530	1,545	1,564	1,567									6,206
PACE	335	345	356	368									1,404
TOTAL	**755,893**	**762,032**	**728,074**	**743,465**									**2,989,464**

ENROLLMENT:

Overall October enrollment was 743,465

- Unfavorable to budget 4,196 or 0.6%
- Increased 15,391 or 2.1% from prior month (PM) (September 2019) due to prior year (PY) retroactive disenrollment adjustment recorded in September
- Decreased 29,381 or 3.8% from PY (October 2018)

Medi-Cal enrollment was 727,437

- Unfavorable to budget 4,266 or 0.6%
  - Medi-Cal Expansion (MCE) unfavorable 4,613
  - Whole Child Model (WCM) unfavorable 1,180
  - Seniors and Persons with Disabilities (SPD) favorable 812
  - Temporary Assistance for Needy Families (TANF) favorable 606
  - Long-Term Care (LTC) favorable 109
- Increased 15,469 from prior month

OneCare Connect enrollment was 14,093

- Unfavorable to budget 2
- Decreased 93 from prior month

OneCare enrollment was 1,567

- Favorable to budget 66 or 4.4%
- Increased 3 from prior month

PACE enrollment was 368

- Favorable to budget 6 or 1.7%
- Increased 12 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
727,437	**731,703**	**(4,266)**	**(0.6%)**	**Member Months**	**2,925,228**	**2,936,933**	**(11,705)**	**(0.4%)**
				Revenues				
281,973,095	268,898,321	13,074,774	4.9%	Capitation revenue	1,193,344,905	1,077,076,632	116,268,273	10.8%
-	-	-	0.0%	Other income	-	-	-	0.0%
281,973,095	**268,898,321**	**13,074,774**	**4.9%**	**Total Operating Revenue**	**1,193,344,905**	**1,077,076,632**	**116,268,273**	**10.8%**
				Medical Expenses				
97,380,910	95,065,186	(2,315,724)	(2.4%)	Provider capitation	384,446,712	381,157,759	(3,288,953)	(0.9%)
49,801,617	48,741,210	(1,060,406)	(2.2%)	Facilities	199,978,832	193,432,949	(6,545,882)	(3.4%)
27,454,041	23,381,276	(4,072,764)	(17.4%)	Professional Claims	105,913,890	92,517,727	(13,396,163)	(14.5%)
46,146,089	44,461,520	(1,684,569)	(3.8%)	Prescription drugs	178,473,206	176,509,035	(1,964,172)	(1.1%)
45,265,759	37,554,255	(7,711,504)	(20.5%)	MLTSS	157,067,776	148,749,866	(8,317,910)	(5.6%)
4,293,029	4,651,261	358,232	7.7%	Medical management	14,565,859	18,092,293	3,526,434	19.5%
1,827,162	3,195,711	1,368,548	42.8%	Reinsurance & other	110,616,444	12,783,642	(97,832,803)	(765.3%)
272,168,607	**257,050,419**	**(15,118,188)**	**(5.9%)**	**Total Medical Expenses**	**1,151,062,719**	**1,023,243,271**	**(127,819,448)**	**(12.5%)**
9,804,487	**11,847,902**	**(2,043,414)**	**(17.2%)**	**Gross Margin**	**42,282,186**	**53,833,361**	**(11,551,174)**	**(21.5%)**
				Administrative Expenses				
6,800,670	7,505,145	704,475	9.4%	Salaries, wages & employee benefits	25,449,195	29,095,325	3,646,130	12.5%
97,590	393,289	295,699	75.2%	Professional fees	682,192	1,474,573	792,381	53.7%
578,224	954,253	376,029	39.4%	Purchased services	2,989,906	3,817,013	827,107	21.7%
217,167	442,570	225,403	50.9%	Printing and postage	1,025,900	1,770,622	744,722	42.1%
365,300	455,750	90,450	19.8%	Depreciation and amortization	1,531,156	1,823,000	291,844	16.0%
1,492,623	1,675,765	183,142	10.9%	Other operating expenses	6,098,543	6,600,433	501,890	7.6%
(167,527)	(175,514)	(7,987)	(4.6%)	Indirect cost allocation, Occupancy Expense	(765,769)	(695,676)	70,093	10.1%
9,384,047	**11,251,258**	**1,867,212**	**16.6%**	**Total Administrative Expenses**	**37,011,124**	**43,885,290**	**6,874,166**	**15.7%**
				Grant Income				
(22,740)	-	(22,740)	0.0%	Grant Revenue	5,786	-	5,786	0.0%
(17,654)	-	17,654	0.0%	Grant expense - Service Partner	(17,717)	-	17,717	0.0%
3,680	-	(3,680)	0.0%	Grant expense - Administrative	32,269	-	(32,269)	0.0%
(8,766)	-	(8,766)	**0.0%**	**Total Grant Income**	(8,766)	-	(8,766)	**0.0%**
-	**-**	**-**	**0.0%**	**Other income**	**135**	**-**	**135**	**0.0%**
411,675	**596,644**	**(184,969)**	**(31.0%)**	**Change in Net Assets**	**5,262,431**	**9,948,071**	**(4,685,640)**	**(47.1%)**
96.5%	***95.6%***	***(0.9%)***	***(1.0%)***	***Medical Loss Ratio***	***96.5%***	***95.0%***	***(1.5%)***	***(1.5%)***
3.3%	***4.2%***	***0.9%***	***20.5%***	***Admin Loss Ratio***	***3.1%***	***4.1%***	***1.0%***	***23.9%***

MEDI-CAL INCOME STATEMENT - OCTOBER MONTH:

REVENUES of $282.0 million are favorable to budget $13.1 million driven by:

- Unfavorable volume related variance of $1.6 million
- Favorable price related variance of $14.6 million due to:
  - ➢ $12.0 million of fiscal year (FY) 2020 Department of Healthcare Services (DHCS) year to date (YTD) acuity rate adjustment
  - ➢ $1.0 million of Coordinated Care Initiative (CCI) revenue
  - ➢ $3.9 million of Behavioral Health Treatment (BHT) revenue
  - ➢ Offset by $3.3 million of WCM revenue

MEDICAL EXPENSES of $272.2 million are unfavorable to budget $15.1 million driven by:

- Favorable volume related variance of $1.5 million
- Unfavorable price variance of $16.6 million due to:
  - ➢ **MLTSS** unfavorable variance of $7.9 million due to YTD true-up
  - ➢ **Professional Claims** unfavorable variance of $4.2 million due to crossover claims
  - ➢ **Provider Capitation** unfavorable variance of $2.9 million due to increase in Proposition 56

ADMINISTRATIVE EXPENSES of $9.4 million are favorable to budget $1.9 million driven by:

- Salaries & Benefit expenses are favorable to budget $0.7 million due to open positions
- Other Non-Salary expenses are favorable to budget $1.2 million

CHANGE IN NET ASSETS is $0.4 million for the month, unfavorable to budget $0.2 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Four Months Ending October 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,093	**14,095**	**(2)**	**(0.0%)**	**Member Months**	**56,626**	**56,622**	**4**	**0.0%**
				Revenues				
2,359,375	2,780,496	(421,121)	(15.1%)	Medi-Cal Capitation revenue	9,609,425	11,193,640	(1,584,215)	(14.2%)
16,662,214	16,201,575	460,639	2.8%	Medicare Capitation revenue part C	67,259,348	65,002,854	2,256,494	3.5%
5,110,082	4,783,241	326,841	6.8%	Medicare Capitation revenue part D	21,066,713	19,168,089	1,898,624	9.9%
-	-	-	0.0%	Other Income	-	-	-	0.0%
24,131,671	**23,765,312**	**366,359**	**1.5%**	**Total Operating Revenue**	**97,935,487**	**95,364,583**	**2,570,904**	**2.7%**
				Medical Expenses				
11,177,818	10,892,036	(285,782)	(2.6%)	Provider capitation	45,515,971	43,778,102	(1,737,869)	(4.0%)
3,640,768	3,520,120	(120,648)	(3.4%)	Facilities	14,704,556	13,979,638	(724,918)	(5.2%)
803,297	689,981	(113,316)	(16.4%)	Ancillary	2,764,537	2,726,260	(38,277)	(1.4%)
1,415,822	1,569,209	153,387	9.8%	Long Term Care	5,571,420	6,263,183	691,763	11.0%
6,221,481	5,469,246	(752,235)	(13.8%)	Prescription drugs	22,871,579	21,703,325	(1,168,254)	(5.4%)
1,026,323	1,146,595	120,272	10.5%	Medical management	4,158,399	4,457,808	299,409	6.7%
248,648	217,852	(30,796)	(14.1%)	Other medical expenses	753,606	866,596	112,990	13.0%
24,534,156	**23,505,039**	**(1,029,117)**	**(4.4%)**	**Total Medical Expenses**	**96,340,069**	**93,774,912**	**(2,565,157)**	**(2.7%)**
(402,485)	**260,273**	**(662,758)**	**(254.6%)**	**Gross Margin**	**1,595,418**	**1,589,671**	**5,747**	**0.4%**
				Administrative Expenses				
715,271	852,317	137,046	16.1%	Salaries, wages & employee benefits	2,829,499	3,325,960	496,461	14.9%
248,180	77,796	(170,384)	(219.0%)	Professional fees	432,524	311,184	(121,340)	(39.0%)
159,021	242,989	83,968	34.6%	Purchased services	708,866	971,955	263,089	27.1%
(8,640)	95,860	104,500	109.0%	Printing and postage	173,704	383,441	209,737	54.7%
-	-	-	0.0%	Depreciation & amortization	-	-	-	0.0%
30,927	71,888	40,961	57.0%	Other operating expenses	43,737	287,553	243,816	84.8%
519,792	519,792	-	0.0%	Indirect cost allocation	2,137,924	2,079,168	(58,756)	(2.8%)
1,664,550	**1,860,642**	**196,092**	**10.5%**	**Total Administrative Expenses**	**6,326,254**	**7,359,261**	**1,033,007**	**14.0%**
(2,067,035)	**(1,600,369)**	**(466,666)**	**(29.2%)**	**Change in Net Assets**	**(4,730,836)**	**(5,769,590)**	**1,038,754**	**18.0%**
101.7%	***98.9%***	***(2.8%)***	***(2.8%)***	***Medical Loss Ratio***	***98.4%***	***98.3%***	***(0.0%)***	***(0.0%)***
6.9%	***7.8%***	***0.9%***	***11.9%***	***Admin Loss Ratio***	***6.5%***	***7.7%***	***1.3%***	***16.3%***

ONECARE CONNECT INCOME STATEMENT - OCTOBER MONTH:

REVENUES of $24.1 million are favorable to budget $0.4 million driven by:

- Unfavorable volume related variance of $3.4 thousand
- Favorable price related variance of $369.7 thousand

MEDICAL EXPENSES of $24.5 million are unfavorable to budget $1.0 million

- Favorable volume related variance of $3.3 thousand
- Unfavorable price related variance of $1.0 million

ADMINISTRATIVE EXPENSES of $1.7 million are favorable to budget $0.2 million

CHANGE IN NET ASSETS is ($2.1) million, unfavorable to budget $0.5 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,567	**1,501**	**66**	**4.4%**	**Member Months**	**6,206**	**5,989**	**217**	**3.6%**
				Revenues				
1,219,649	1,114,379	105,270	9.4%	Medicare Part C revenue	5,036,553	4,449,857	586,696	13.2%
561,938	519,797	42,141	8.1%	Medicare Part D revenue	2,220,039	2,069,017	151,022	7.3%
1,781,586	**1,634,176**	**147,410**	**9.0%**	**Total Operating Revenue**	**7,256,593**	**6,518,874**	**737,719**	**11.3%**
				Medical Expenses				
476,579	441,581	(34,998)	(7.9%)	Provider capitation	1,914,396	1,763,254	(151,142)	(8.6%)
371,491	511,496	140,005	27.4%	Inpatient	1,510,475	2,024,164	513,689	25.4%
47,332	55,847	8,515	15.2%	Ancillary	178,450	221,061	42,611	19.3%
16,690	45,887	29,197	63.6%	Skilled nursing facilities	39,246	181,612	142,366	78.4%
609,140	506,192	(102,948)	(20.3%)	Prescription drugs	2,125,151	2,006,926	(118,225)	(5.9%)
28,715	49,678	20,963	42.2%	Medical management	147,023	194,944	47,921	24.6%
-	10,833	10,833	100.0%	Other medical expenses	-	43,225	43,225	100.0%
1,549,947	**1,621,514**	**71,567**	**4.4%**	**Total Medical Expenses**	**5,914,741**	**6,435,186**	**520,445**	**8.1%**
231,639	**12,662**	**218,977**	**1729.4%**	**Gross Margin**	**1,341,852**	**83,688**	**1,258,164**	**1503.4%**
				Administrative Expenses				
61,353	54,355	(6,998)	(12.9%)	Salaries, wages & employee benefits	227,222	211,406	(15,816)	(7.5%)
54,371	21,480	(32,891)	(153.1%)	Professional fees	99,371	85,920	(13,451)	(15.7%)
12,329	17,063	4,734	27.7%	Purchased services	66,516	68,252	1,736	2.5%
2,051	16,667	14,616	87.7%	Printing and postage	16,488	66,668	50,180	75.3%
654	4,738	4,084	86.2%	Other operating expenses	1,001	18,952	17,951	94.7%
35,589	35,589	-	0.0%	Indirect cost allocation, occupancy expens	155,627	142,356	(13,271)	(9.3%)
166,346	**149,892**	**(16,454)**	**(11.0%)**	**Total Administrative Expenses**	**566,226**	**593,554**	**27,328**	**4.6%**
65,293	**(137,230)**	**202,523**	**147.6%**	**Change in Net Assets**	**775,626**	**(509,866)**	**1,285,492**	**252.1%**
87.0%	***99.2%***	***12.2%***	***12.3%***	***Medical Loss Ratio***	***81.5%***	***98.7%***	***17.2%***	***17.4%***
9.3%	***9.2%***	***(0.2%)***	***(1.8%)***	***Admin Loss Ratio***	***7.8%***	***9.1%***	***1.3%***	***14.3%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
368	**362**	**6**	**1.7%**	**Member Months**	**1,404**	**1,406**	**(2)**	**-0.1%**
				Revenues				
2,283,275	2,177,933	105,342	4.8%	Medi-Cal capitation revenue	8,717,079	8,453,257	263,822	3.1%
463,987	502,367	(38,380)	(7.6%)	Medicare Part C revenue	1,765,803	1,964,677	(198,874)	(10.1%)
72,513	133,231	(60,719)	(45.6%)	Medicare Part D revenue	433,031	518,660	(85,629)	(16.5%)
2,819,774	**2,813,531**	**6,243**	**0.2%**	**Total Operating Revenue**	**10,915,913**	**10,936,594**	**(20,681)**	**(0.2%)**
				Medical Expenses				
703,206	913,304	210,098	23.0%	Medical Management	2,753,770	3,545,167	791,397	22.3%
751,670	536,874	(214,796)	(40.0%)	Claims payments to hospitals	2,852,736	2,062,734	(790,002)	(38.3%)
595,103	588,694	(6,409)	(1.1%)	Professional claims	2,199,296	2,264,206	64,910	2.9%
198,090	234,863	36,773	15.7%	Patient transportation	875,675	893,837	18,162	2.0%
238,098	223,883	(14,215)	(6.3%)	Prescription drugs	890,662	860,232	(30,430)	(3.5%)
41,964	24,076	(17,888)	(74.3%)	MLTSS	134,306	86,346	(47,960)	(55.5%)
4,600	6,667	2,067	31.0%	Other Expenses	17,912	26,667	8,755	32.8%
2,532,731	**2,528,361**	**(4,370)**	**(0.2%)**	**Total Medical Expenses**	**9,724,356**	**9,739,189**	**14,833**	**0.2%**
287,043	**285,170**	**1,873**	**0.7%**	**Gross Margin**	**1,191,557**	**1,197,405**	**(5,848)**	**-0.5%**
				Administrative Expenses				
150,908	150,657	(251)	(0.2%)	Salaries, wages & employee benefits	561,745	585,098	23,353	4.0%
420	153	(267)	(174.7%)	Professional fees	889	612	(277)	(45.3%)
7,897	18,971	11,074	58.4%	Purchased services	46,165	75,884	29,719	39.2%
43,876	10,533	(33,343)	(316.6%)	Printing and postage	44,609	42,132	(2,477)	(5.9%)
2,092	2,116	24	1.1%	Depreciation & amortization	8,368	8,464	96	1.1%
4,893	4,135	(758)	(18.3%)	Other operating expenses	15,039	16,543	1,504	9.1%
3,770	4,000	230	5.8%	Indirect cost allocation, Occupancy Expense	33,678	15,746	(17,932)	(113.9%)
213,855	**190,565**	**(23,290)**	**(12.2%)**	**Total Administrative Expenses**	**710,494**	**744,479**	**33,985**	**4.6%**
				Operating Tax				
5,461	-	5,461	0.0%	Tax Revenue	20,835	-	20,835	0.0%
5,461	-	(5,461)	0.0%	Premium tax expense	20,835	-	(20,835)	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
73,187	**94,605**	**(21,418)**	**(22.6%)**	**Change in Net Assets**	**481,063**	**452,926**	**28,137**	**6.2%**
89.8%	***89.9%***	***0.0%***	***0.0%***	***Medical Loss Ratio***	***89.1%***	***89.1%***	***(0.0%)***	***(0.0%)***
7.6%	***6.8%***	***(0.8%)***	***(12.0%)***	***Admin Loss Ratio***	***6.5%***	***6.8%***	***0.3%***	***4.4%***

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2019

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				
50,068	23,101	(26,967)	(116.7%)	Purchase services	197,429	92,404	(105,025)	(113.7%)
164,494	174,725	10,231	5.9%	Depreciation & amortization	657,975	698,900	40,925	5.9%
17,476	15,866	(1,610)	(10.2%)	Insurance expense	69,906	63,464	(6,442)	(10.2%)
121,487	140,162	18,675	13.3%	Repair and maintenance	442,281	560,648	118,367	21.1%
61,645	46,432	(15,213)	(32.8%)	Other Operating Expense	246,785	185,728	(61,057)	(32.9%)
(415,170)	(400,286)	14,884	3.7%	Indirect allocation, Occupancy	(1,614,376)	(1,601,144)	13,232	0.8%
(0)	**-**	**0**	**0.0%**	**Total Administrative Expenses**	**(0)**	**-**	**0**	**0.0%**
0	**-**	**0**	**0.0%**	**Change in Net Assets**	**0**	**-**	**0**	**0.0%**

OTHER INCOME STATEMENTS - OCTOBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $65.3 thousand, favorable to budget $202.5 thousand

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $73.2 thousand, unfavorable to budget $21.4 thousand

CalOptima
Balance Sheet
October 31, 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$490,688,657	Accounts Payable	$5,908,235
Investments	452,003,433	Medical Claims liability	740,621,652
Capitation receivable	288,273,944	Accrued Payroll Liabilities	14,443,246
Receivables - Other	41,492,825	Deferred Revenue	39,591,614
Prepaid expenses	5,272,886	Deferred Lease Obligations	19,076
		Capitation and Withholds	154,489,926
Total Current Assets	**1,277,731,744**	**Total Current Liabilities**	**955,073,749**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	10,161,507		
505 City Parkway West	50,489,717		
	97,737,589		
Less: accumulated depreciation	(48,883,835)		
Capital assets, net	48,853,754	Other (than pensions) post	
		employment benefits liability	25,208,920
Other Assets		Net Pension Liabilities	23,599,664
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,003,882,333**
Cash and Cash Equivalents	3,635,814		
Long-term Investments	562,103,130	Deferred Inflows	
Total Board-designated Assets	565,738,944	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	624,237,857	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**1,950,823,355**	TNE	105,737,627
		Funds in Excess of TNE	844,887,009
Deferred Outflows		**TOTAL NET POSITION**	950,624,636
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,961,913,804**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**1,961,913,804**

CalOptima
Board Designated Reserve and TNE Analysis
as of October 31, 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	155,076,251				
	Tier 1 - Logan Circle	153,868,433				
	Tier 1 - Wells Capital	154,335,289				
Board-designated Reserve		463,279,972	296,575,264	468,995,074	166,704,708	(5,715,102)
TNE Requirement	Tier 2 - Logan Circle	102,458,972	105,737,627	105,737,627	(3,278,655)	(3,278,655)
	Consolidated:	**565,738,944**	**402,312,891**	**574,732,701**	**163,426,053**	**(8,993,757)**
	Current reserve level	*1.97*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
October 31, 2019

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	2,394,214	15,081,766
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	531,886	2,197,500
Changes in assets and liabilities:		
Prepaid expenses and other	755,573	514,855
Catastrophic reserves		
Capitation receivable	5,382,697	22,174,998
Medical claims liability	(110,986,459)	(11,689,300)
Deferred revenue	180,928	(11,443,150)
Payable to providers	10,654,723	45,586,786
Accounts payable	339,754	(33,322,719)
Other accrued liabilities	231,618	476,085
Net cash provided by/(used in) operating activities	(90,515,065)	29,576,822
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	83,428,609	121,702,864
Change in Property and Equipment	(1,046,311)	(4,426,364)
Change in Board designated reserves	(1,856,989)	(5,593,537)
Change in Homeless Health Reserve	-	1,801,087
Net cash provided by/(used in) investing activities	80,525,309	113,484,050
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(9,989,756)	143,060,872
CASH AND CASH EQUIVALENTS, beginning of period	$500,678,412	347,627,784
CASH AND CASH EQUIVALENTS, end of period	**490,688,657**	**490,688,657**

BALANCE SHEET - OCTOBER MONTH:

ASSETS of $2.0 billion decreased $97.2 million from September or 4.7%

- **Investments** decreased $83.4 million due to the payout of the State's Directed Payment (DP) received in September
- **Operating Cash** decreased $10.0 million due to the payout of the State's DP received in September
- **Capitation Receivables** decreased $5.7 million due to timing of capitation received from DHCS

LIABILITIES of $1.0 billion decreased $99.6 million from September or 9.0%

- **Medical Claims Liability** decreased $111.0 million due to cash disbursements for DP's
- **Capitation and Withholds** increased $10.7 million due to increase to increase in capitation to health networks and shared risk pool

NET ASSETS total $950.6 million

Homeless Health Initiative and Allocated Funds
as of October 31, 2019

	Amount
Program Commitment	**$ 100,000,000**

Funds Allocation, approved initiatives:

Be Well OC	$	11,400,000
Recuperative Care		11,000,000
Clinical Field Team Start-Up & Federally Qualified Health Center (FQHC)		1,600,000
Homeless Response Team (CalOptima)		6,000,000
Homeless Coordination at Hospitals		10,000,000
CalOptima Day & QI Program		1,231,087
FQHC – Expansion		570,000
Funds Allocation Total		**41,801,087**
Program Commitment Balance, available for new initiatives		**$ 58,198,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories. This report only lists Board approved projects.

Budget Allocation Changes
Reporting Changes for October 2019

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS Application Development - Maintenance HW/SW (CalOptima Link Software)	IS Application Development - Maintenance HW/SW (Human Resources Corporate Application)	$32,700	Repurpose $32,700 from Maintenance HW/SW (CalOptima Link Software) to Maintenance HW/SW (Huma Resources Corporate Application)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (Server 2016 Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$38,300	Reallocate $38,300 from Capital Project (Server 2016 Upgrade) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (LAN Switch Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$25,700	Reallocate $25,700 from Capital Project (LAN Switch Upgrades) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000. \
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors' Meeting
December 5, 2019

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

- Timeliness Monitoring Project:

  On October 8, 2019, the Centers for Medicare & Medicaid Services (CMS) announced its efforts to collect data for organization determinations, appeals and grievances (ODAG) and coverage determinations, appeals and grievances (CDAG) for the requested review period of February 1, 2018 – April 30, 2019. Findings from this monitoring effort may result in compliance actions, if necessary, and may have implications for the Star Ratings data integrity reviews for the four (4) appeals measures. CalOptima has not been formally notified of its selection for this monitoring effort, but is currently working internally to collect the ODAG/CDAG universes in anticipation of this engagement.

- 2020 CMS Readiness Checklist (applicable to OneCare and OneCare Connect):

  On October 3, 2019, CMS released the 2020 Readiness Checklist for Medicare Advantage organizations and Medicare-Medicaid Plans. Plans are expected to fulfill key operational requirements summarized in the Readiness Checklist for the 2020 benefit year. CalOptima's Office of Compliance is leading the 2020 Readiness Checklist activities with all departments to ensure compliance for requirements impacting their respective operational area(s). The validation audit activities are expected to conclude by the end of 2019.

2. OneCare Connect

- CY 2020 Monitoring of Posted Comprehensive Formularies:

  On October 29, 2019, CMS announced it will be conducting a review to compare the formularies posted on the health plan's websites for CY 2020 with their approved formularies within HPMS that will be effective 1/1/20. CMS will select one-hundred seventy-five (175) Part D contracts for inclusion in the CY 2020 Monitoring of Posted

Comprehensive Formularies Analysis. On October 31, 2019, CMS notified CalOptima that its OneCare Connect program had been selected for this monitoring effort.

- Compliance Program Effectiveness (CPE) Audit (OneCare and OneCare Connect):

  CalOptima is required to conduct an independent audit of its compliance program on an annual basis, and to share the results with its governing body. As such, CalOptima has engaged an independent auditor to ensure that its compliance program is administering the elements of an effective compliance program, as outlined in the CMS Medicare Parts C and D Program Audit Protocols. The audit began in August 2019 and concluded on September 26, 2019. CalOptima is pending the final report from the auditor.

3. Medi-Cal

- 2019 Medi-Cal Audit:

  The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 4 - 15, 2019. The audit covered the review period of February 1, 2018 through January 31, 2019 and consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity. On June 25, 2019, the DHCS issued its final audit report to CalOptima, which outlined three (3) findings in the areas of case management and coordination of care, access and availability of care, and quality management. CalOptima submitted a timely corrective action plan (CAP) to the DHCS, and it is currently under review.

- 2020 DHCS Medical Audit (Medi-Cal and OneCare Connect)

  On November 7, 2019, DHCS sent CalOptima an engagement notice for a medical audit of CalOptima's Medi-Cal and OneCare Connect programs. The onsite audit will take place from January 27, 2019 to February 7, 2019. The audit will cover the review period of February 1, 2019 to January 31, 2020. The audit will cover CalOptima's provision of Medi-Cal services to its non-Seniors and Persons with Disabilities (non-SPD) members, Medi-Cal services for SPDs, as well as Medicaid-based services in OneCare Connect.

  The DHCS will evaluate CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, member's rights, quality management, and administrative and organizational capacity.

- Rate Development Template (RDT) Audit:

  On May 30, 2019, Mercer and the DHCS engaged CalOptima for the RDT audit, which will focus on the accuracy and completeness of calendar year 2017 Medi-Cal RDT encounter and financial data submitted to the DHCS as part of the rate development process for 2019-2020.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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On August 7, 2019, Mercer auditors came onsite to review CalOptima's claims systems as well as conduct staff interviews. CalOptima anticipates a final draft report from Mercer in the near future. CalOptima will have one (1) week to provide any feedback before Mercer communicates the report to the DHCS for final review and approval.

- Department of Managed Health Care (DMHC) Routine Examination:

  On August 8, 2019, the DMHC engaged CalOptima for its tri-annual routine examination. This examination will review CalOptima's fiscal and administrative affairs and will include an examination of CalOptima's financial reports. CalOptima's last routine examination was conducted in 2016. The DMHC conducted its entrance conference with CalOptima on October 21, 2019, and the DMHC expects to conclude its active examination in mid-November 2019.

- CMS Medicaid Expansion Medical Loss Ratio (MLR) Examination:

  On April 1, 2019, CMS informed CalOptima that it will perform a comprehensive examination and validation of California Medicaid managed care plans' MLR reporting for the reporting periods January 1, 2014 to June 30, 2015 and July 1, 2015 to June 30, 2016. The overall purpose of the examination is to ensure that the financial information submitted by the Medicaid managed care plans and used by the DHCS to perform the MLR calculations is consistent with contractual obligations and matches each Medicaid managed care plan's internal data and accounting systems. CMS expects that the review will be completed within six (6) months after all the data have been received by the reviewing contractor. The commencement date of the examination has yet to be established, but CalOptima expects to begin receiving data requests soon.

4. PACE Level of Care Audit

- On November 14, 2019, the DHCS will be onsite for the PACE Level of Care (LOC) audit, which is conducted twice a year. The review period will be April 2019 through September 2019. The purpose of the audit is to ensure the information PACE submitted on the initial and annual LOC documents is consistent with the assessments documented by the interdisciplinary team (IDT) members.

B. Regulatory Notices of Non-Compliance

CalOptima did not receive any notices of non-compliance from its regulators for the month of October 2019. However, on October 25, 2019, CalOptima's OneCare Connect program received a request from CMS and the DHCS for a Performance Improvement Plan (PIP) for failure to meet satisfactory rates of Individualized Care Plan (ICP) completion, in compliance with contractual standards and the specifications for the performance measure related to completing member care plans within 90 days of enrollment.

CMS and the DHCS is requesting for a PIP to address the root cause for the low ICP completion rate and a plan of action to achieve a 6-month goal of 75% ICP completion rate. The PIP is due to

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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CMS and DHCS by November 22, 2019. CMS has indicated that this letter will not be included in CalOptima's record for Medicare contract performance.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2019	100%	100%	100%	100%
July 2019	100%	97%	100%	93%
August 2019	100%	100%	100%	100%

➢ For the August 2019 file review of Medi-Cal claims, CalOptima's Claims department received a compliance score of 100% for a focused audit of sixty (60) claims selected for review and a compliance score of 99% for timeliness based on the overall universe of professional claims.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Paper PDRs Acknowledged within ≤ 15 Business Days	PDRs Resolved within ≤ 45 Business Days	Accurate PDR Determinations	Clear and Specific PDR Resolution Language	Interest Accuracy and Timeliness within ≤ 5 Business Days
June 2019	100%	100%	95%	100%	100%
July 2019	98%	100%	98%	100%	100%
August 2019	100%	100%	95%	98%	100%

➢ For the August 2019 file review of Medi-Cal PDRs, CalOptima's Claims department received a compliance score of 99% for a focused audit of forty (40) claims selected for review and a compliance score of 99% for timeliness based on the overall universe of PDRs.
  - The lower compliance score of 95% for accurate PDR determinations for August 2019 was due to two (2) inaccurate PDR determinations.
  - The lower compliance score of 98% for clear and specific PDR resolution language for August 2019 was due to one (1) inaccurate member notice.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of PDRs. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure accurate and timely processing of PDRs within regulatory requirements.

2. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2019	100%	100%	100%	100%
July 2019	100%	100%	100%	100%
August 2019	100%	100%	100%	100%

- For the August 2019 file review of OneCare claims, CalOptima's Claims department received a compliance score of 100% on a focused audit of twenty (20) claims selected for review and a compliance score of 99% for timeliness based on the overall universe of paid and denied claims.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Resolution Timeliness	Accurate PDR Determinations	Clear and Specific PDR Resolution Language
June 2019	Nothing to Report	Nothing to Report	Nothing to Report
July 2019	100%	100%	100%
August 2019	Nothing to Report	Nothing to Report	Nothing to Report

- For the July 2019 file review of OneCare PDRs, CalOptima's Claims department received a compliance score of 100% for timeliness based on the overall universe of PDRs.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of standard grievances within regulatory requirements.

3. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2019	100%	100%	100%	90%
July 2019	100%	90%	100%	100%
August 2019	100%	90%	100%	100%

- For the August 2019 file review of OneCare Connect claims, CalOptima's Claims department received a compliance score of 98% for a focused audit of twenty (20) paid and denied claims selected for review and a compliance score of 99% for timeliness based on the overall universe of professional claims.

- The lower compliance score of 90% for paid claims accuracy for August 2019 was due to one (1) inaccurate claim.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy
June 2019	100%	100%	100%
July 2019	100%	100%	100%
August 2019	100%	88%	100%

  - For the August 2019 file review of OneCare Connect PDRs, CalOptima's Claims department received a compliance score of 96% for a focused audit of eight (8) PDRs selected for review and a compliance score of 99% for timeliness based on the overall universe of PDRs.

  - The lower compliance score of 88% for accurate resolution timeliness for August 2019 was due to one (1) untimely PDR.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of PDRs. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure accurate and timely processing of PDRs within regulatory requirements.

4. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
June 2019	80%	100%	100%	100%
July 2019	100%	100%	100%	100%
August 2019	100%	100%	100%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- For the August 2019 file review of PACE claims, CalOptima's Claims department received a score of 100% for a focused audit of twenty (20) claims selected for review.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Resolution Timeliness	Check Lag
June 2019	100%	100%	100%	50%
July 2019	100%	100%	100%	N/A
August 2019	100%	100%	100%	N/A

- For the August 2019 file review of PACE PDRs, CalOptima's Claims department received a score of 100% for a focused audit of two (2) PDRs selected for review.

- PACE: Service Delivery Requests (SDRs)

Month	SDR Denials	SDR Approvals
June 2019	100%	100%
July 2019	100%	100%
August 2019	100%	100%

- For the August 2019 file review of PACE SDRs, CalOptima's PACE department received a score of 100% for a focused audit of eight (8) SDRs selected for review.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- PACE: Alternative Care Setting (ACS) Facility Site Review

Facility	Compliance Score
Acacia Adult Day Services	89%
SeniorServ - Anaheim Adult Day Health Care Center	79%
SeniorServ - Santa Ana Adult Day Health Care Center	67%
South County Adult Day Services	100%
Sultan Adult Day Health Care	86%

  - Acacia Adult Day Services
    - Based on a focused review of fifty-three (53) elements, Acacia Adult Day Services received a compliance score of 89% due to six (6) noncompliant elements in the following areas --- Maintenance and Housekeeping, General Safety, Patient Rights, Infection Control Plan, and Dietary Services.

  - SeniorServ - Anaheim Adult Day Health Care Center
    - Based on a focused review of fifty-two (52) elements, SeniorServ - Anaheim Adult Day Health Care Center received a compliance score of 79% due to eleven (11) noncompliant elements in the following areas --- Fire Life Safety, Maintenance and Housekeeping, General Safety, and Dietary Services.

  - SeniorServ - Santa Ana Adult Day Health Care Center
    - Based on a focused review of fifty-one (51) elements, SeniorServ - Santa Ana Adult Day Health Care Center received a compliance score of 67% due to seventeen (17) noncompliant elements in the following areas --- Fire Life Safety, Maintenance and Housekeeping, General Safety, Patient Rights, Personnel/ Administration and Dietary Services.

  - South County Adult Day Services
    - Based on a focused review of fifty-seven (57) elements, South County Adult Day Services received a compliance score of 100%.

  - Sultan Adult Day Health Care
    - Based on a focused review of fifty-one (51) elements, Sultan Adult Day Health Care received a compliance score of 86% due to seven (7) noncompliant elements in the following areas --- Fire Life Safety, Maintenance and Housekeeping, General Safety, and Patient Rights.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the facility site reviews. The A&O department continues to work with the facilities to remediate the deficiencies by

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identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure compliant sites.

5. Internal Audit: Medi-Cal, Medi-Cal Wrap Pharmacy [a\]

- CalOptima's Audit & Oversight (Internal) department performed an annual audit on CalOptima's Pharmacy Department for the Medi-Cal line of business to assess DHCS audit readiness and compliance with other applicable regulatory requirements. The audit will cover the review period of February 1, 2019 through May 31, 2019. The audit areas include:
  - Medi-Cal Pharmacy Prior Authorizations
  - Medi-Cal Pharmacy Appeals
  - OneCare Connect Pharmacy Prior Authorizations (for products covered under Medi-Cal "wrap" benefit only)
  - OneCare Connect Pharmacy Appeals (for products covered under Medi-Cal "wrap" benefit only)

- Medi-Cal, Medi-Cal Wrap Prior Authorizations:

  - Timeliness:
    - 4 of 20 files reviewed failed to meet the applicable deferral, decision, and/or notification turnaround time requirements.

  - Clinical Decision-Making:
    - 3 of 20 files reviewed failed to meet clinical decision-making requirements such as inappropriately issued denials and lack of regular criteria review/updates.

  - Processing Requirements:
    - 3 of 20 files reviewed failed to meet processing requirements such as providing prescriber notifications, readability of Notice of Actions (NOAs), and proper categorization of requests.

- Medi-Cal, Medi-Cal Wrap Appeals Results:

  - Timeliness:
    - 4 of 20 files reviewed failed to meet decision-making and/or notification timeliness requirements.

  - Clinical Decision-Making:
    - 3 of 20 files reviewed failed to meet clinical decision-making requirements such as inappropriate denial rationale, inappropriate outreach/request for information, and inconsistent decision-making.

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- Processing Requirements:
  - No findings, observations, or recommendations were noted during the processing requirements review.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of pharmacy prior authorizations and appeals. The A&O department continues to work with the Pharmacy department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure accurate and timely processing of pharmacy prior authorizations and appeals within regulatory requirements.

6. Internal Audit: Medicare Pharmacy [a\]

- CalOptima's Audit & Oversight (Internal) department performed an internal audit on Pharmacy Management's Medicare lines of business to assess CMS program audit readiness and compliance with applicable regulatory requirements. The audit will cover the review period of October 1, 2018 through January 31, 2019. The audit areas include:
  - Part C Organization Determinations, Appeals and Grievances (ODAG) (as it relates to Part B drugs)
  - Medicare-Medicaid Plan (MMP) Service Authorizations Requests, Appeals and Grievances (SARAG) (as it relates to Part B drugs)
  - Part D Formulary Administration (FA)
  - Part D Coverage Determinations, Appeals and Grievances (CDAG)

- Formulary and Benefit Administration Results:

  - Formulary Administration Review:
    - No findings, observations, or recommendations noted during the review.
    - 30 of 30 claims passed the validation test to determine if the claims adjudication process followed the CMS-approved formulary.

  - Transition Review:
    - No findings, observations, or recommendations were noted during the review.
    - 15 of 15 claims passed the validation test to determine if applicable transition fill requirements were met.
    - 1 of 1 sample claims passed the validation test to determine if transition notice requirements were met.

  - Website Review:
    - No findings, observations, or recommendations were noted during the review.
    - 15 of 15 drugs passed the validation test to determine if the marketed formulary accurately reflected the CMS-approved formulary for the audit review period.

- Part D Coverage Determinations, Appeals, and Grievances Results:

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- Timeliness:
  - 1 case exceeded turnaround time requirements for decision notification and was not forwarded to independent review entity (IRE).
  - 1 case exceeded turnaround time requirements for decision notification/effectuation and was forwarded to the IRE, but IRE forward was untimely.

- Clinical Decision-Making:
  - Incomplete denial rationale in denial notice to member and prescriber
  - No formulary alternatives provided based on the member's specific diagnosis

- Part C Organization Determinations, Appeals, and Grievances Results:

  - Timeliness:
    - No findings, observations, or recommendations were noted during the review.

  - Clinical Decision-Making:
    - For 1 case, there were 3 issues identified --- 1) incorrectly issued approval under Part D instead of Part B, 2) incorrectly sent Part D approval notice to the member/prescriber/pharmacy, 3) significantly delayed reissuance (>1 month) of a corrected approval notice to member/prescriber.

- Medicare-Medicaid Plan Service Authorization Requests, Appeals, and Grievances:

  - Timeliness:
    - No findings, observations, or recommendations were noted during the review.

  - Clinical Decision-Making:
    - No findings, observations, or recommendations were noted during the review.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of prior authorizations and appeals. The A&O department continues to work with the Pharmacy department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure accurate and timely processing of prior authorizations and appeals within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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7. Health Network Monitoring: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
June 2019	82%	91%	93%	88%	76%	89%	93%	82%	94%	92%	67%	100%	100%
July 2019	85%	86%	93%	89%	91%	92%	94%	86%	90%	96%	100%	100%	100%
August 2019	55%	86%	93%	59%	59%	92%	92%	80%	92%	91%	67%	89%	67%

- Based on a focused review of select files, eight (8) health networks drove the lower compliance score for timeliness. For these health networks, all thirty-eight (38) of the files selected were deficient. Deficiencies for the lower scores for timeliness include the following:
  - Failure to meet timeframe for decision (Urgent -72 hours, Routine – 5 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)

- Based on a focused review of select files, one (1) health network drove the lower compliance score for clinical decision making (CDM). For this health network, two (2) of the two (2) files selected were deficient. Deficiencies for the lower scores for CDM include the following:
  - Failure to obtain appropriate professional to make decision.

- Based on a focused review of select files, two (2) health networks drove the lower compliance letter score. For these health networks, all six (6) of the files selected were deficient. Deficiencies for the lower letter scores include the following:
  - Failure to provide member with information on how to file a grievance
  - Failure to provide letter in member preferred language
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to include name and contact information for health care professional responsible for the decision to deny or modify

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– Failure to provide peer-to-peer discussion of the decision with medical reviewer

➢ Based on the overall universe of Medi-Cal authorizations for July 2019, CalOptima's health networks received an aggregate compliance score of 99% for timely processing of routine authorization requests and a compliance score of 96% for timely processing of expedited authorization requests.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2019	97%	94%	100%	94%
July 2019	99%	95%	99%	91%
August 2019	94%	88%	95%	92%

➢ Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 99% in July 2019 to 94% in August 2019 due to untimely processing of multiple claims. The lower score was driven by two (2) health networks with an aggregate of two (2) files marked deficient for timeliness out of the aggregate total of six (6) files received for August 2019.

➢ Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 95% in July 2019 to 88% in August 2019 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by four (4) health networks with an aggregate of five (5) files marked deficient for accuracy out of the aggregate total of fourteen (14) files received for August 2019**.**

➢ Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 99% in July 2019 to 95% in August 2019 due to untimely processing of multiple claims. The lower score was driven by two (2) health networks with an aggregate of four (4) files marked deficient for timeliness out of the aggregate total of fourteen (14) files received for August 2019.

➢ Based on the overall universe of Medi-Cal claims for July 2019, CalOptima's health networks received an overall compliance score of 92% for timely processing of claims.

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- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

8. Health Network Monitoring: OneCare

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
June 2019	85%	100%	99%	93%	93%	80%	79%	95%
July 2019	93%	100%	95%	96%	96%	100%	73%	94%
August 2019	92%	100%	100%	100%	93%	100%	83%	99%

- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness. For this health network, one (1) out of the two (2) files received was deficient. Deficiencies for the lower score for timeliness include the following:
  - Failure to meet timeframe for decision (expedited)
  - Failure to meet timeframe for member oral notification (expedited)
  - Failure to meet timeframe for provider notification (expedited)

- Based on a focused review of select files, one (1) health network drove the lower score for clinical decision making (CDM). For this health network, two (2) of the fourteen (14) files received were deficient. The lower scores for CDM was due to failure to cite criteria for decision.
  - Based on a focused review of select files, two (2) health networks drove the lower scores for letter language. For these health networks, all three (3) files received were deficient. The lower score for letter language was due to failure to provide letter with description of services in lay language.

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for July 2019, CalOptima's health networks received an overall compliance score of 99% for timely processing of standard Part C authorization requests and 94% for timely processing of expedited Part C authorization requests.

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- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2019	100%	95%	100%	95%
July 2019	99%	93%	99%	82%
August 2019	94%	100%	94%	94%

- Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 99% in July 2019 to 94% in August 2019 due to untimely processing of multiple claims. The lower score was driven by one (1) health network that had one (1) out of two (2) files received marked as deficient for timeliness for August 2019.

- Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 99% in July 2019 to 94% in August 2019 due to untimely processing of multiple claims. The lower score was driven by one (1) health network that had one (1) out of two (2) files received marked as deficient for timeliness for August 2019.

- Based on the overall universe of OneCare claims for CalOptima's health networks for June 2019, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 83% for non-contracted clean claims paid or denied within 30 calendar days of receipt; and
  - 96% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited

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to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

9. Health Network Monitoring: OneCare Connect

- 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
June 2019	80%	100%	90%	81%	90%	80%	80%	83%	63%	90%	84%
July 2019	89%	95%	89%	95%	86%	91%	74%	85%	100%	82%	87%
August 2019	85%	100%	92%	68%	87%	70%	77%	88%	90%	90%	93%

- Based on a focused review of select files, seven (7) health networks drove the lower compliance score for timeliness. For these health networks, fourteen (14) of the twenty-three (23) files received were deficient. Deficiencies for the lower scores for timeliness include the following:
  - Failure to meet timeframe for decision (Urgent -72 hours; Routine – 5 Business Days)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to meet timeframe for provider written notification (24 hours)

- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for July 2019, CalOptima's health networks received an overall compliance score of 100% for timely processing of routine authorization requests and 98% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

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- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2019	93%	93%	99%	91%
July 2019	100%	87%	99%	96%
August 2019	90%	95%	96%	95%

- Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 100% in July 2019 to 90% in August 2019 due to untimely processing of multiple claims. The lower score was driven by two (2) health networks with two (2) of the four (4) files received marked as deficient for timeliness for August 2019.

- Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 99% in July 2019 to 96% in August 2019 due to untimely processing of multiple claims. The lower score was driven by two (2) health networks with two (2) of the nine (9) files received marked as deficient for timeliness for August 2019.

- Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 96% in July 2019 to 95% in August 2019 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by two (2) health networks with two (2) of the eight (8) files received marked as deficient for denied claim accuracy for August 2019.

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for July 2019, CalOptima's health networks received the following overall compliance scores:
  - 96% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 100% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
  - 99% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and

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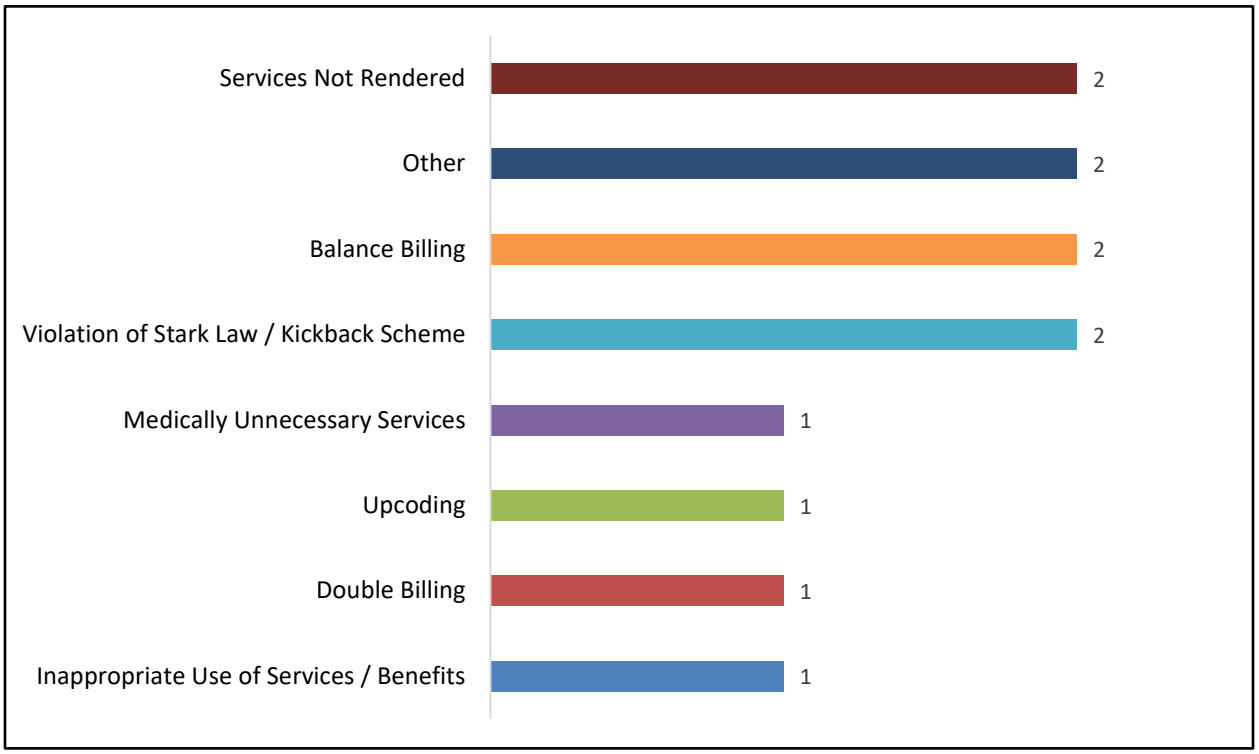
policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

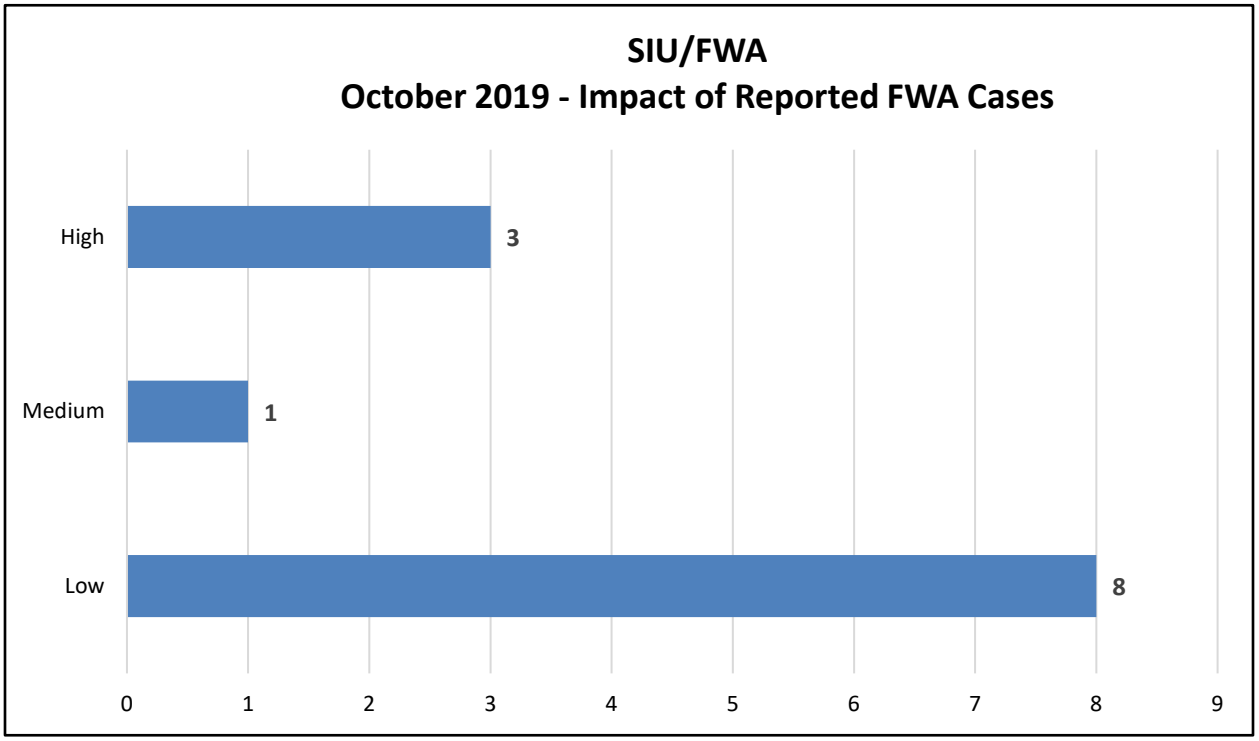
a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in October 2019)

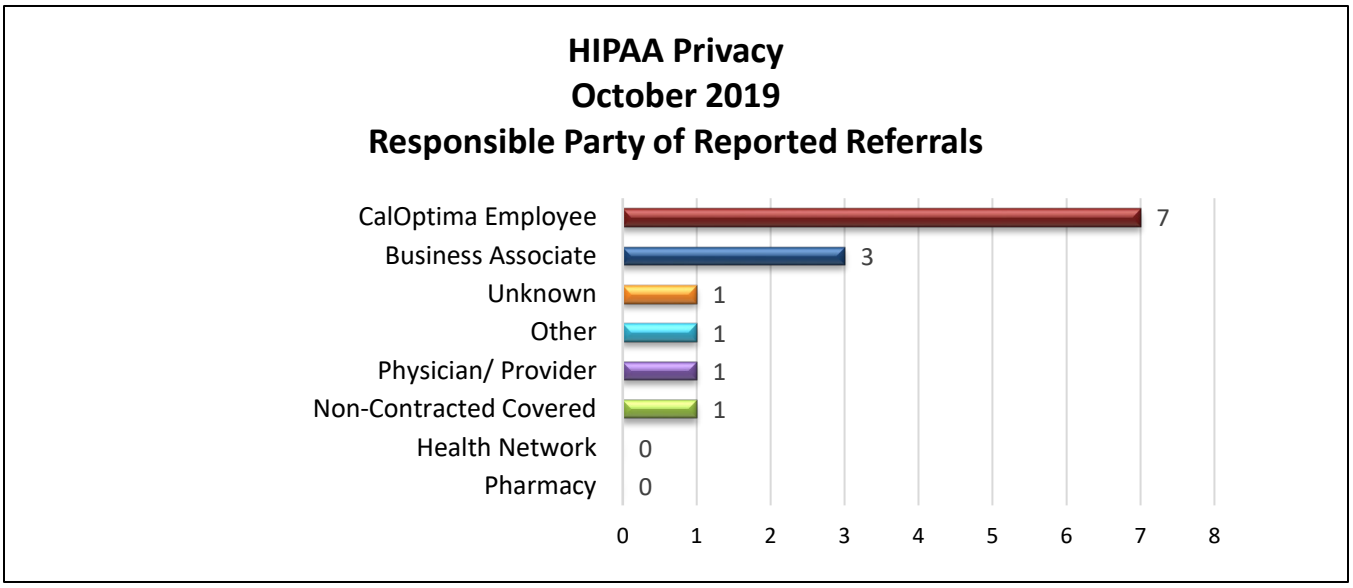


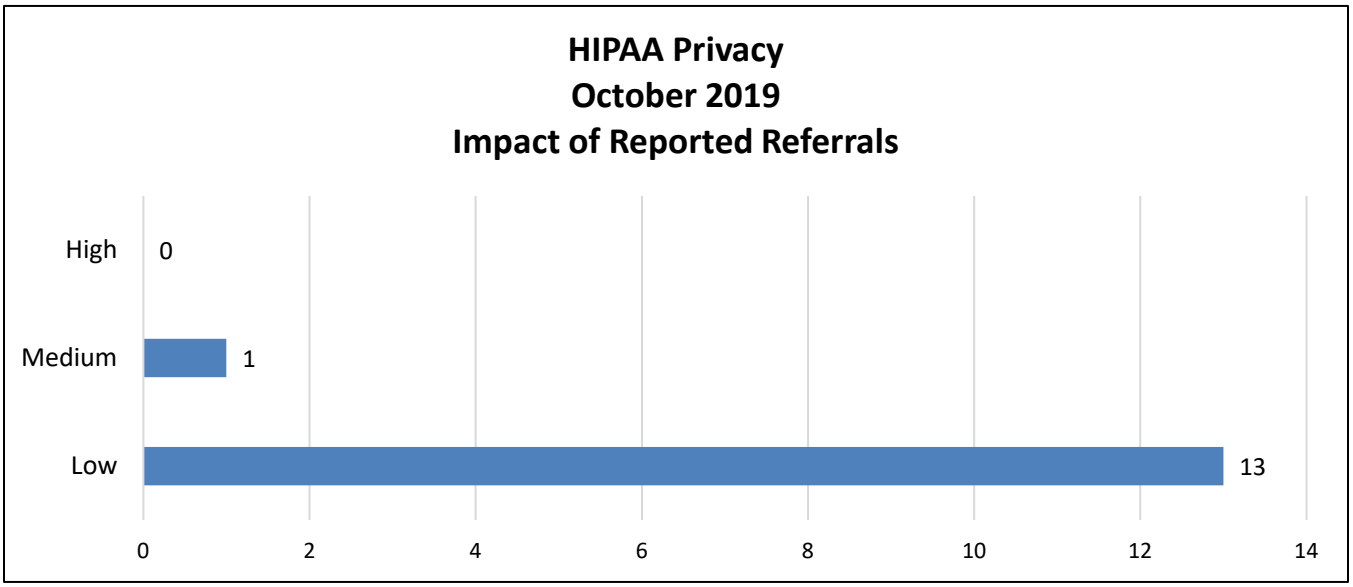


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E. Privacy Update (October 2019)





Total Number of Referrals Reported to DHCS (State)	14
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**14**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

November 11, 2019

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: November 11 Board of Directors Report

Partisan tensions in Washington are high as the first public hearings begin as part of House Democrats' presidential impeachment inquiry. Meanwhile, the Senate has made little progress on appropriations, and with a broad funding deal out of reach, it is expected that another stopgap spending measure will be needed to keep the federal government running past November 21. All of this activity increases the likelihood that action on key health care items such as drug pricing and surprise billing could slip into next year. This report provides an update on activity through November 10, 2019.

FY 2020 Budget and Appropriations

On October 31, the Senate passed a four-bill "minibus" that combines the Fiscal Year (FY) 2020 Agriculture-FDA, Commerce-Justice-Science, Interior-Environment, and Transportation-HUD appropriations bills. The bills now head to conference with the House. Another four-bill package (H.R. 2740) that includes the Defense, Labor-HHS-Education, State Foreign-Operations and Energy-Water bills failed a procedural vote amid partisan disagreement over funding levels and controversy around border security and abortion. With little time remaining before the current Continuing Resolution (CR) expires on November 21, at least one more stopgap bill will be required to prevent a funding lapse. While Senate Appropriations Chairman Richard Shelby (R-AL) initially floated the idea of a CR that would extend into February of next year, recent reports indicate that Senate Majority Leader Mitch McConnell (R-KY) and House Majority Leader Steny Hoyer (D-MD) favor a CR that expires by December 20. The House will consider the CR the week of November 18.

There is little appetite in Congress for a shutdown, especially coming up on a crucial election year, but President Trump has refused to rule out the possibility of a funding lapse if Democrats do not stop their impeachment inquiry.

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Drug Pricing Legislation

The House Energy and Commerce, Ways and Means, and Education and Labor Committees last month each marked up H.R. 3, the Elijah Cummings Lower Drug Costs Now Act, making minor changes to the bill such as clarifying the impact on the 340B Drug Pricing Program. A preliminary analysis from the Congressional Budget Office (CBO) found that the drug price negotiation provisions in the legislation would reduce federal spending by $345 billion over 10 years, while leading to a reduction of 8 to 15 new drugs coming to market over the same period. Lawmakers are still awaiting a final score from CBO, meaning that the bill is unlikely to receive floor consideration until December. In any case, Senate Majority Leader Mitch McConnell (R-KY) has made clear that he will not take up H.R. 3 if it passes the House.

White House Domestic Policy Chief Joe Grogan is urging Congress to instead pass the Senate Finance Committee's Prescription Drug Pricing Reduction Act (S. 2543). While Grogan signaled that the Administration would be open to dropping the inflationary rebate provisions in the bill which have drawn the ire of many Republican senators, Finance Chairman Chuck Grassley (R-IA) may be unwilling to make such a concession. Given the significant Republican opposition to the bill, Majority Leader McConnell (R-KY) has not committed to bringing the Finance package to the floor. It is growing more likely that action on drug pricing could be pushed to next year.

Surprise Billing

Work continues behind the scenes to find a bipartisan solution on surprise medical billing. Leaders of the House Energy and Commerce Committee and the Senate Health, Education, Labor and Pensions (HELP) Committee continue to discuss areas of agreement between their respective bills. They may seek to include a "compromise" surprise billing proposal in order to advance the issue prior to a contentious impeachment trial and as a way to pay for another extension of health care "extender" provisions, such as a delay of the Medicaid Disproportionate Share Hospital (DSH) pay cuts, which will expire with the current stopgap. Members are also hoping to delay or repeal several Affordable Care Act (ACA) taxes by December 31, including the medical device excise tax, the so-called "Cadillac tax" on high-cost employer health plans, and the health insurance tax.

While Committee leaders have favored a benchmark payment methodology for surprise billing, final legislation is likely to include some element of arbitration. Grogan recently suggested that lawmakers are close to an agreement and suggested that it could move separately from drug pricing.

Impact of Impeachment Proceedings

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On October 31, the House voted 232-196 largely along party lines to officially establish procedures for public impeachment hearings. Hearings are scheduled already for November 13 and 15, and another week of public hearings is expected to follow.

Impeachment proceedings threaten to derail plans for congressional action on drug pricing and surprise billing this year, as a lengthy impeachment trial in Senate would consume valuable floor time in the Senate. In addition, some lawmakers are worried that the divisiveness of public impeachment proceedings would disrupt bipartisan negotiations on health care issues, making it much harder to find a solution amenable to congressional leaders and the White House. Still, there is significant pressure for Congress to pass a number of health care extender provisions before year-end, and these could be wrapped up in a CR or other appropriations vehicle.

Medicaid News

On October 30, the Senate Finance Committee Health Care Subcommittee held a hearing on Medicaid eligibility. Republicans used the hearing to call for stronger federal oversight of state eligibility procedures, citing recent reports from the Government Accountability Office (GAO) and the HHS Office of Inspector General (OIG) that found large amounts of improper payments going to enrollees who may not have been Medicaid-eligible. On the other side, Democrats argued that burdensome enrollment rules actually prevent many eligible Americans from being covered by the program.

On November 6, the Centers for Medicare & Medicaid Services (CMS) announced the approval of a new Section 1115 Medicaid waiver in the District of Columbia that aims to expand access to behavioral health treatment services for individuals with serious mental illness (SMI), serious emotional disturbance (SED), and/or substance use disorder (SUD). The demonstration will allow D.C. to receive payment for treating individuals with SMI or SUD who are short-term residents in institutions for mental disease (IMDs).

Medicaid work requirements have seen several recent setbacks. Democrat Andy Beshear's victory over incumbent Gov. Matt Bevin (R) in Kentucky's gubernatorial race makes it all but certain that the state will abandon its plan for imposing work requirements. In addition, Indiana announced October 31 that it is suspending its Medicaid work requirements pending a federal lawsuit that was filed in September. Arizona also informed CMS that it is postponing implementation of work requirements following several federal court rulings that blocked similar requirements in other states earlier this year.

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Universal Health Care

While Democratic Presidential hopefuls continue to debate the merits – and financing – of single payer coverage, little action has transpired on the Medicare for All Act (H.R. 1384), which is sponsored by a majority of House Democrats. Meanwhile, Rep. Ro Khanna (D-CA) on November 8 introduced the State-Based Universal Health Care Act (H.R. 5010), legislation that would create a federal waiver for a state or group of states to establish state or regional universal health care systems. In order to apply for the waiver and federal funding, participants' proposals must aim to cover 95 percent of residents within five years. Rep. Khanna said in a statement that the legislation would allow "bold states like California [to] take the lead in making Medicare for All a reality."

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Report to CalOptima Board of Directors

Akin Gump
STRAUSS HAUER & FELD LLP

December 5, 2019

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Agenda

1. **The 2020 Outlook**: Campaigns Takeover
   a) The Race to Take on President Trump
   b) The Races to Represent Orange County
2. **The Federal Health Policy & Politics**
   a) In Congress
   b) From the Administration
   c) On the Trail
3. **Questions?**



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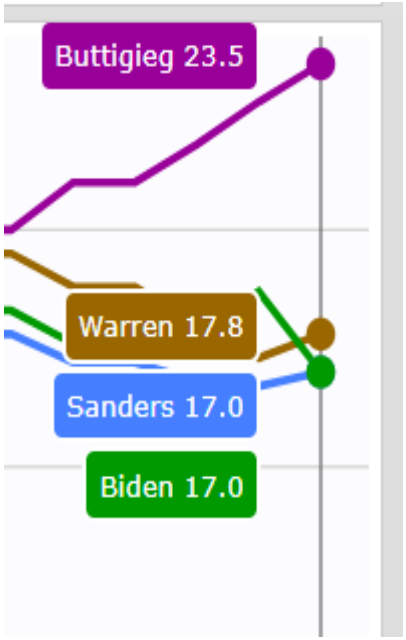
The Democratic Presidential Primary

The Calendar

Feb 3:	IA
Feb 11:	NH
Feb 22:	NV
Feb 29:	SC
Mar 3:	CA, TX, NC, GA, VA
Mar 10:	OH, MI
Mar 17:	FL, IL
Apr 28:	NY, PA, MD
July 13-16:	DNC Convention
Nov 3:	Election Day

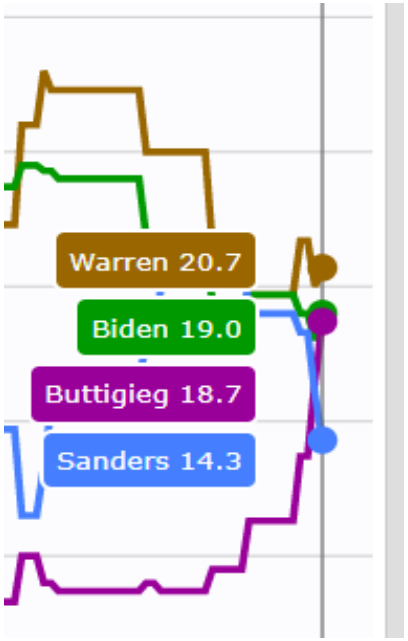
Iowa

(polling avg on 11/21/2019)



New Hampshire

(polling avg on 11/21/2019)



Key Questions

- What happens when national polling frontrunner, Joe Biden, loses first two contests?
- Will the African-American vote consolidate behind one candidate?

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The Race for the U.S. House & Orange County

The Battle for the House Majority Shifts Geographically

- In 2018, Democrats needed to net gain 23 seats. There were 4 in Orange County held by Republicans that Hillary Clinton won in 2016. Democrats won all 4 and flipped 39 more.

- In 2020, Republicans need to net gain 21 seats. There are now 31 districts held by Democrats that Trump won in 2016. None are in California. (4 are in NY and NJ each, 3 in IA, 2 in IL, MI, MN, PA, and VA)

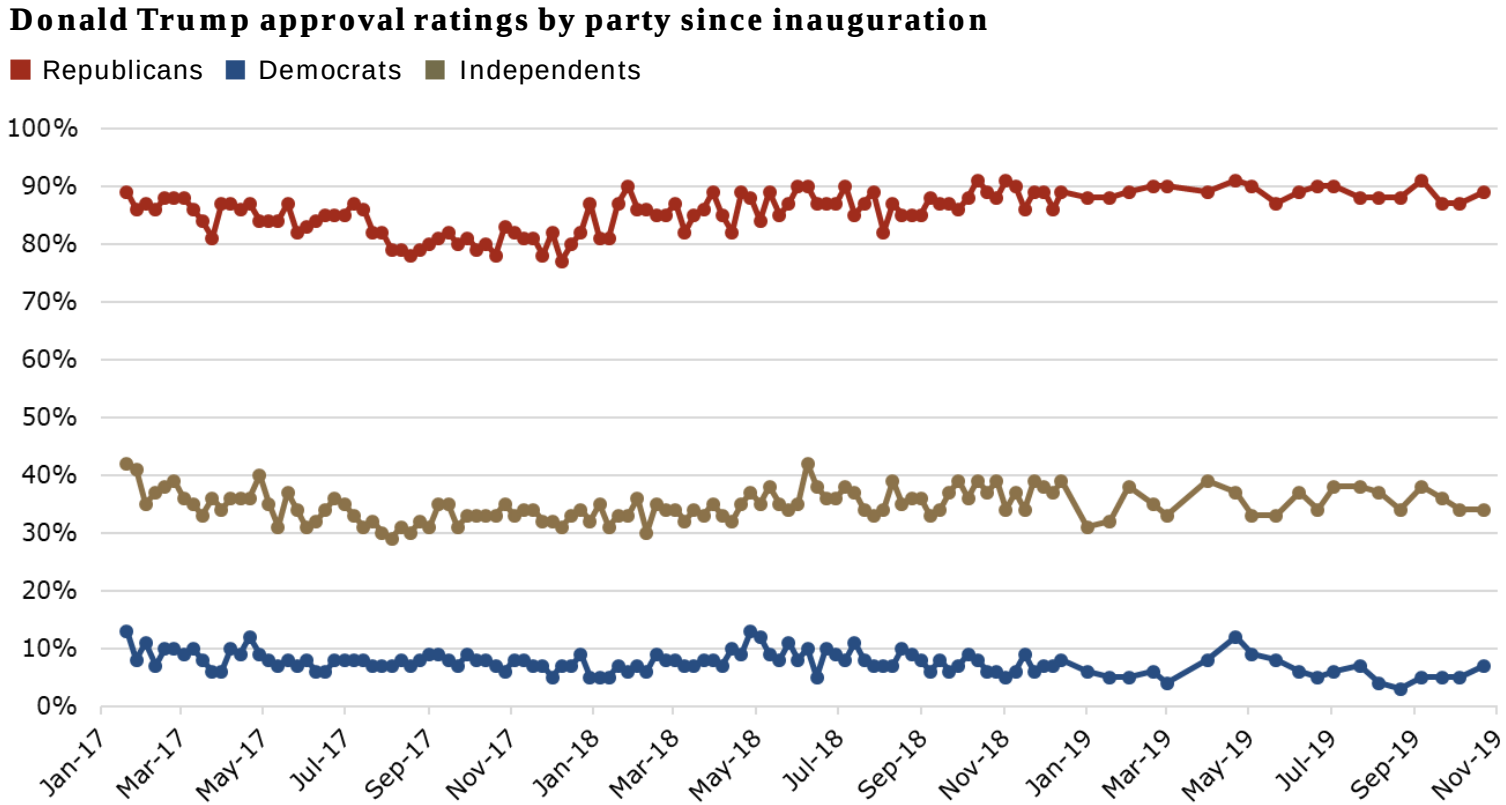
District	Incumbent	Outlook*
CA-38	Rep. Linda Sanchez (D)	Solid D
CA-39	Rep. Gil Cisneros (D)	Lean D
CA-45	Rep. Katie Porter (D)	Lean D
CA-46	Rep. Lou Correa (D)	Solid D
CA-47	Rep. Alan Lowenthal (D)	Solid D
CA-48	Rep. Harley Rouda (D)	Lean D
CA-49	Rep. Mike Levin (D)	Likely D

*SOURCE: Cook Political Report

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Trump Approval Steady

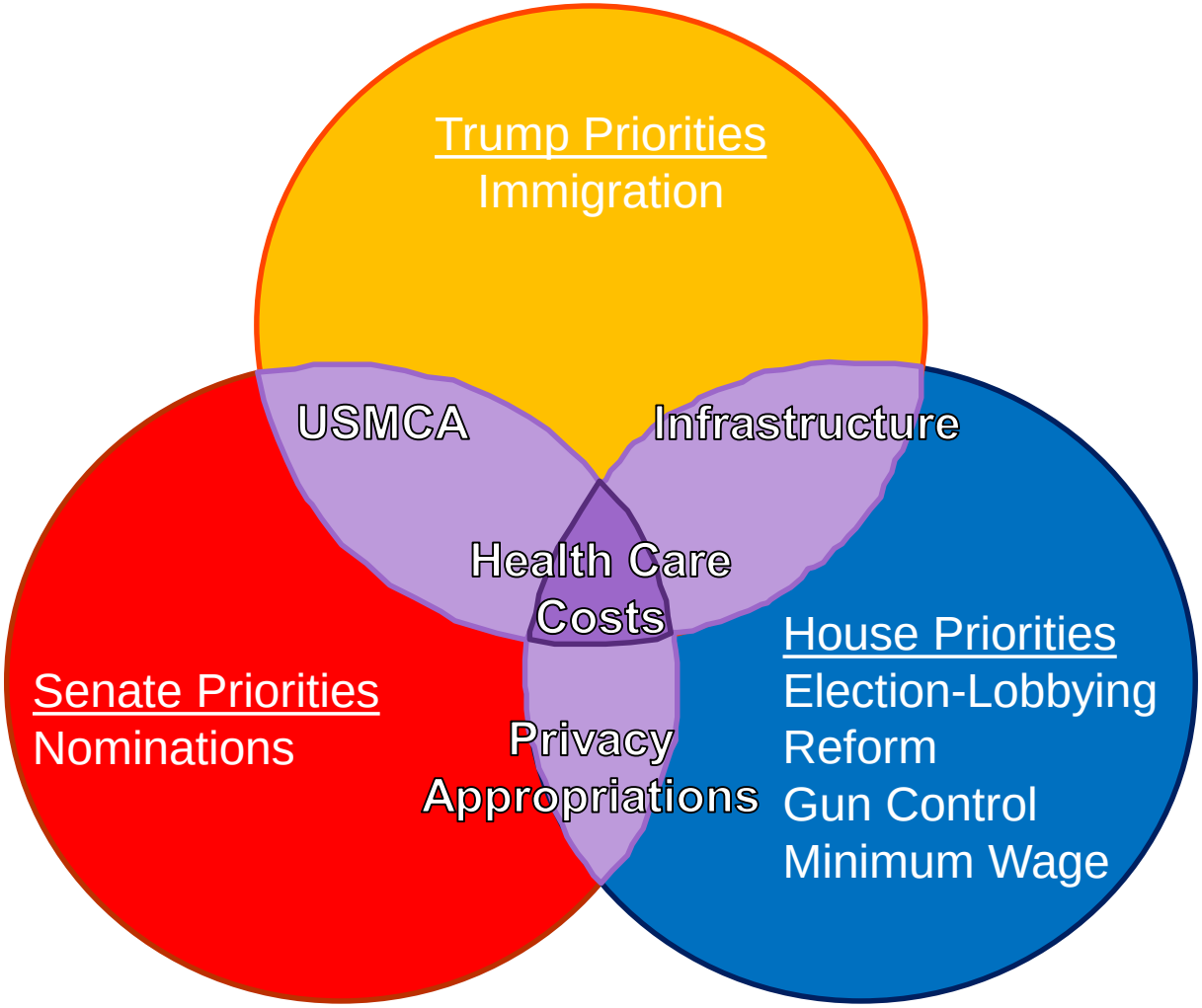
President Trump's approval ratings have remained consistent throughout his presidency



Source: Gallup

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Governing in Gridlock



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Health Policy Outlook in Congress

- **Drug Pricing**
  - House expected to pass H.R. 3, but will not be taken up by the Senate
  - White House urging passage of Senate Finance package (S. 2543), but no bipartisan solution in sight
- **Surprise Medical Billing**
  - Senate HELP and House Energy & Commerce in discussions around bipartisan solution
    - Likely to include rate setting with some role for arbitration
  - Outlook: Could be attached to year-end spending deal as a pay-for for health care extenders
- **Health Care Extenders**
  - Bipartisan pressure to pass longer-term extensions of key public health programs, as well as a two-year delay of Medicaid DSH payment cuts
  - Bipartisan desire to further delay Affordable Care Act taxes (Cadillac tax, medical device excise tax, health insurance tax)

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Health Care Regulatory Outlook

- Trump Administration expected to accelerate deregulatory agenda in what could be final year in office
  - Incremental Medicaid reform efforts through regulation
    - Mixed signals on block granting Medicaid
    - Continued approval of Medicaid work requirements despite legal setbacks
    - Opposition to "partial" Medicaid expansions
    - Expanded efforts to enhance program integrity, eligibility checks
  - Desire to streamline state waiver processes, reduce gaming of federal matching
  - "Public Charge" Final Rule
    - Limits the ability of immigrants to become citizens or permanent residents if they have receive benefits such as Medicaid or CHIP
    - Likely to be tied up in courts
- *Texas v. United States*
  - Awaiting ruling from the Fifth Circuit Court of Appeals
  - Could invalidate the entire ACA, including the Medicaid expansion

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Universal Coverage Means and Ends

How to achieve **universal coverage** –"Medicare for All" vs. expanding the Affordable Care Act – is the clearest dividing line in Democratic Presidential primary with significant down-ballot implications

- ***It's Academic***: with current Senate rules, a M4A plan will not pass
- ***Why Do It?*** Message bold change vs. incremental improvement
  - Supports M4A: Sanders, Warren
  - Prefers ACA: Biden, Booker, Buttigieg, Harris, Klobuchar
- ***The Risks are Real***
  - H.R. 1384, Rep. Jayapal (D-WA) – 118 cosponsors, half of House Ds
  - S. 1129, Sen. Sanders (I-VT) – 14 cosponsors (including Booker, Harris, Warren since introduction in April 2019)
  - Strong M4A plans like those above would significantly curtail access to employer-sponsored private insurance
- ***Universal Coverage Alternatives***
  - Medicare-X – Sens. Kaine (D-VA) and Bennet (D-CO)
  - Medicare Buy-In at 50 – Sen. Stabenow (D-MI)
  - Medicaid Buy-In – Sen. Schatz (D-HI)
  - State-Based Universal Health Care Act (H.R. 5010) – Rep. Khanna (D-CA)

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CalOptima
Legislative Report
November 8, 2019
By Don Gilbert and Trent Smith

The Legislature and Governor have concluded their work for 2019, but there is no time to rest. The Governor and the Department of Health Care Services (DHCS) have released a major policy proposal that will consume the health care world in Sacramento throughout 2020. The new initiative is called California Advancing and Innovating Medi-Cal (CalAIM). Its goals are to identify and manage member risk and need through more holistic approaches and addressing the social determinants of health. Also, the initiative strives to move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility. Finally, CalAIM is intended to improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

The initiative is outlined in a 180 page document. In addition, DHCS is hosting several stakeholder meetings over the next several months. Key issues that will be discussed include:

- Requiring Medi-Cal managed care plans to submit Population Health Management strategies and moving to annual Medi-Cal managed care plan open enrollment.

- Adding a new Enhanced Care Management benefit and a set of In Lieu of Services, designed to focus on critical populations such as children, high-cost/high-need populations, and the homeless, among others.

- Behavioral Health payment reform and delivery system transformation, with particular emphasis on how to improve critical needs for children.

- Requiring the National Committee on Quality Assurance (NCQA) accreditation for Medi-Cal managed care plans.

- Considerations for creation of Full Integration Plans where one entity would be responsible for the physical, behavioral, and oral health needs of their members.

It appears that one of the primary goals of CalAIM is the better coordination of care for Medi-Cal enrollees who have complex medical conditions requiring care from multiple delivery systems (managed care, fee-for-service, mental health, substance abuse disorder, dental, developmental, In Home Supportive Services, etc.). In this regard, County Organized Health Systems (COHS) are uniquely qualified to provide input in the stakeholder process, and ultimately succeed in achieving the goals of CalAIM, as coordinating care is a core principle of the COHS model.

CalAIM will look to the successes of waiver demonstrations such as the Whole Person Care and the Coordinated Care Initiative as the basis for many of its suggested reforms. Preventive care will also be an emphasis, which again is guiding principle of the COHS model.

There also appears to be an emphasis on care for and treating the growing homeless population and even identifying populations that could become homeless. Behavior health and expanding health plans' ability to assist in coordinating housing opportunities are important goals of CalAIM.

Also included in the initiative is better care planning and mandatory enrollment for inmates as they prepare for release. Adding oral health and better coordinate care for foster youth are also stated goals of the initiative.

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS is recommending requiring all Medi-Cal managed care plans and their subcontractors (delegated entities) to be National Committee for Quality Assurance (NCQA) accredited by 2025. DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements. Obviously, this proposal is of no concern to CalOptima, as it already is NCQA accredited.

Another major issue for COHS could be the recommendation to shift Medi-Cal managed care plan rates from a county-based model to a regional rate model, which will coincide with a shift of the rating period from the state fiscal year to the calendar year beginning in 2020. DHCS argues the move to regional rates has two main benefits. The first benefit is a decreased number of distinct actuarial rating cells that are required and submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS with goal of allowing DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates will allow cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging rather than just the experience of plans within the county. DHCS further argues this change is fundamental to the ability for them to implement the other changes proposed in CalAIM.

As previously mentioned, DHCS will hold a series of stakeholder meetings between now and February 2020. DHCS plans to finalize all proposals for submission to the federal government sometime between May and July depending on input from stakeholders.

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We also assume there will multiple legislative hearings, although it appears that much of what is proposed in CalAIM does not require legislative approval. DHCS appears to have the authority to move forward with most of the recommended policy changes included in CalAIM with only federal approval. However, the Legislature will have some leverage in shaping CalAIM through the budget process as state funding will be necessary to achieve many of the stated goals.

There will be much to report in the coming months as interested parties weigh in with thoughts and concerns regarding the development of CalAIM. This initiative is seen by many as groundbreaking, but like most major policy reforms, there is sure to be controversy and apprehension. Let the debate begin.

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2019–20 Legislative Tracking Matrix

BUDGET BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 3877	**Bipartisan Budget Act of 2019:** Will enact a two-year framework for the federal budget (through fiscal year 2021). This bill gives a broad blueprint for federal spending and prevents the implementation of automatic spending cuts – also known as sequestration – that are triggered, generally, when Congress misses budget deadlines. Of note, the passing of the Bipartisan Budget Act of 2019 removed proposed spending cuts to Medicaid.	**08/02/2019** Signed into law	CalOptima: Watch
AB 74	**FY 2019-20 California State Budget:** Will enact a $214.8 billion spending plan for FY 2019-20, with General Fund (GF) spending at $147.8 billion. The following included within the state budget will have a direct impact to Medi-Cal: ■ Updates on the Pharmacy Services carve-out ■ Revisions to the expansion of Medi-Cal ■ Proposition 56 supplemental payment funding ■ Funding to respond to the homelessness crisis	**06/30/2019** Signed into law	CalOptima: Watch
AB 101	**Housing Development and Financing Budget:** Will enact housing trailer bills in the California 2019-2020 budget. Housing Development and Financing budget trailer bills include policy changes related to the housing and homeless services budget, including: ■ $650 million in grant funding for homeless services ■ Bypassing certain California Environmental Quality Act (CEQA) regulations to expedite the establishment of homeless shelters	**07/31/2019** Signed into law	CalOptima: Watch
AB 115	**Managed Care Organization (MCO) Tax Renewal:** Proposes a renewal of, until 12/31/2022, and new structure for the MCO tax, which would be effective retroactive to 7/1/2019.	**09/26/2019** Signed into law **09/12/2019** Passed Senate floor **09/12/2019** Passed Assembly floor **12/03/2018** Introduced	CalOptima: Watch CAHP: Support LHPC: Support
SB 78	**Health Budget:** Will enact health care trailer bills in the California 2019-2020 budget. ■ Prop 56 Value Based Payment (VBP) Behavioral Health integration program ■ Optional benefit restoration (optician and optical services, audiology, speech therapy, podiatry, and incontinence creams) ■ Health Homes Program (HHP) funding extension until 7/1/2024 ■ State-based Individual Mandate ■ Managed Care Organization (MCO) Tax renewal intent language	**06/27/2019** Signed into law	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 104	**Health Budget:** Will enact health care trailer bills in the California 2019-2020 budget. ■ Expansion of full-scope Medi-Cal ages 19-25 regardless of immigration status ■ Eligibility expansion for low-income seniors (122% FPL to 138% FPL) ■ Extension of maternal-mental health Medi-Cal coverage ■ Implementation of a PACE rate adjustment	**07/09/2019** Signed into law	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 577 Eggman	**Maternal Mental Health Care Services:** Extends eligibility for an individual to receive maternal mental health care services through the Medi-Cal Access Program for women below 213% federal poverty level from 60 days post-pregnancy to 12 months post-pregnancy or the diagnosis of a maternal mental health condition. Medi-Cal postpartum care services are covered for any individual who was pregnant and experienced child birth, delivery or miscarriage. Of note, the extension of maternal mental health services was included in the Governor's May Revision budget and signed into law with the passing of SB 104.	**10/12/2019** Signed into law **09/03/2019** Passed Senate floor **05/24/2019** Passed Assembly floor **02/14/2019** Introduced	CalOptima: Watch
AB 1175 Wood	**Medi-Cal Mental Health Services Data Sharing:** Would have required the monthly exchange of member data between a County Specialty Mental Health Plan (MHP) and a Medi-Cal Managed Care Plan (MCP) for any member that has received or is receiving specialty mental health services. The use of a data exchange system was to be mutually agreed upon between the MHP and MCP. Data collected was to be used to improve care coordination for those with mild, moderate or severe mental health needs. Any disputes regarding covered mental health services between the MHP and MCP would have been required to be resolved by the Department of Health Care Services within 30 calendar days.	**10/13/2019** Vetoed **09/04/2019** Passed Senate floor **05/28/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch
SB 10 Beall	**Mental Health Support Services Certificate:** Would have created the Certified Support Specialist (CSS) certificate program, which would have allowed parents, peers, and family to become a CSS. A CSS would have been able to provide non-medical mental health and substance abuse support services. Additionally, SB 10 would have required the Department of Health Care Services (DHCS) to include CSS as a provider type, covered by Medi-Cal. The certificate program would have been funded through Mental Health Services Act funds and, if federally approved, the peer-support program would have been funded through Medi-Cal reimbursement.	**10/13/2019** Vetoed **09/05/2019** Passed Assembly floor **05/21/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 163 Portantino	**Autism Spectrum Disorder (ASD) Treatment:** Would have revised and expanded the definitions of those providing care and support to individuals with Autism Spectrum Disorder (ASD) and redefined the minimum qualifications of autism service professionals. Additionally, ASD treatment such as the Developmental Individual-differences, and Relationship-based model (DIR), or "DIRFloortime," not currently covered by Medi-Cal, would have been authorized to be provided at any time or location, in an unscheduled and unstructured setting, by a qualified autism provider. The authorization of ASD treatment services would not have been denied or limited if a parent or caregiver is unable to participate.	**10/12/2019** Vetoed **09/09/2019** Passed Assembly floor **05/22/2019** Passed Senate floor **01/24/2019** Introduced	CalOptima: Watch CAHP: Oppose AHIP: Oppose

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4618 McBath	**Medicare Hearing Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of hearing aids for Medicare beneficiaries. Hearing aids would be provided every five years and would require a prescription from a doctor or qualified audiologist.	**10/17/2019** Passed the Committee on Energy and Commerce **10/08/2019** Introduced	CalOptima: Watch
H.R. 4650 Kelly	**Medicare Dental Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of dental health services for Medicare beneficiaries. Covered benefits would include preventive and screening services, basic and major treatments, and other care related to oral health.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
H.R. 4665 Schrier	**Medicare Vision Act of 2019:** No sooner than January 1, 2022, would require Medicare Part B to cover the cost of vision care for Medicare beneficiaries. Covered benefits would include routine eye exams and corrective lenses. Corrective lenses covered would be either one pair of conventional eyeglasses or contact lenses.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
AB 678 Flora	**Podiatric Services as a Medi-Cal Covered Benefit:** Modifies authorizations of services so that a podiatrist would no longer be required to submit prior authorization for services during the patient's visit if a physician and surgeon providing the same services would not be required to submit prior authorization. Additionally, removes the limit on how many visits the patient can make to a podiatrist. Permits a podiatrist to bill Medi-Cal the same rate that a physician or surgeon would bill for the same services.	**10/02/2019** Signed into law **08/15/2019** Passed Senate floor **05/23/2019** Passed Assembly floor **02/15/2019** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 781 Maienschein	**Pediatric Day Health Care (PDHC) Services:** Expands PDHC service hours to any day of the week and at any time of the day, so long the number of respite hours allocated are available. Would allow no more than 23 hours per calendar day of covered services. Currently, a parent or guardian may seek PDHC services up to 30 calendar days each year and for no more than 24 hours at a time. PDHC services are required to be provided by a facility licensed through the Department of Public Health and include both physical and social services. The PDHC benefit is not included in the scope of covered services provided by Medi-Cal managed care plans and is a benefit provided through fee-for-service Medi-Cal.	**07/09/2019** Signed into law **06/27/2019** Passed Senate floor **06/17/2019** Passed Assembly floor **02/19/2019** Introduced	CalOptima: Watch
AB 848 Gray	**Continuous Medi-Cal Coverage for Glucose Monitors:** Would have included glucose monitors as a Medi-Cal covered benefit, to be funded through state reimbursement rates. Cost of the glucose monitoring devices is unknown at this time. The Department of Health Care Services estimated this benefit would have cost $100.8 million total funds ($31.9 million General Fund (GF), $68.9 million Federal Fund (FF)) the first year and $92.7 million total funds ($29.4 million GF, $63.3 million FF) the second year.	**10/13/2019** Vetoed **09/04/2019** Passed Senate floor **05/22/2019** Passed Assembly floor **02/20/2019** Introduced	CalOptima: Watch

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1004 McCarty	**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Developmental Screening Services:** Requires developmental screenings services as part of the EPSDT program for children 0-3 years of age. Recommends developmental screenings take place for children at the age of 9 months, 18 months, and 30 months. All screenings are to be in compliance with developmental screening guidelines set in place by the American Academy of Pediatrics. AB 1004 allows DHCS to adjust capitation rates for providers, with the use of value-based purchasing, as an incentive to improve EPSDT outcomes.	**09/30/2019** Signed into law **09/05/2019** Passed Senate floor **05/23/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1839 Ruiz	**Medicaid Services Investment and Accountability Act of 2019:** Extends spousal impoverishment protections when a spouse is receiving skilled nursing care, provides states the ability to provide coordinated care for children with special needs through the use of health home services, and would require drug manufacturers to disclose drug product information and pay a fine for the misclassification of prescribed medications.	**04/18/2019** Signed into law **04/02/2019** Passed the Senate **03/25/2019** Passed the House **03/21/2019** Introduced	CalOptima: Watch
AB 1088 Wood	**Medi-Cal Eligibility without a Share-of-Cost:** Effective July 1, 2021 through the use of a State Plan Amendment or Waiver, eliminates the "Share of Cost (SOC)" and maintains eligibility for Medi-Cal, for individuals who are aged, blind, or disabled, once the Department of Health Care Services (DHCS) begins to pay for the individual's Medicare Part B premium. Currently, individuals in this eligibility category with income levels above 100 percent FPL are only eligible for Medi-Cal if they pay an added out of pocket expense known as SOC. Under SOC, beneficiaries must take full responsibility for health care expenses up to a predetermined amount for the month in which they receive services or risk losing Medi-Cal eligibility. This bill ensures that individuals have access to Medi-Cal without incurring extra financial burdens.	**10/02/2019** Signed into law **09/05/2019** Passed Senate floor **05/29/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Support
SB 29 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million General Fund, $21 federal funds) by expanding full-scope Medi-Cal to approximately 25,000 adults who are undocumented and 65 years of age and older.	**09/13/2019** Held in Assembly **08/30/2019** Passed Assembly Committee on Appropriations **05/29/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1856 Waters	**Ending Homelessness Act of 2019**: Similar to S. 2613, would establish a federal grant program to appropriate $13 billion, beginning FY 2020 through FY 2024, to fund comprehensive homeless support services. Grant funds would be allocated to address the poverty rate, shortage of affordable housing, overcrowded housing, the number of individuals experiencing homelessness who are unsheltered, individuals experiencing chronic homelessness, and other issues related to homelessness in the United States. Of note, no less than 75% of grants allocated are to be used for permanent supportive housing, including capital costs, rental subsidies, and related services.	**03/25/2019** Introduced; Referred to the Committees on Financial Services; Budget	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1978 Correa/Lieu	**Fighting Homelessness Through Services and Housing Act:** Similar to S. 923, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the House Committee on Financial Services	CalOptima: Watch
S. 923 Feinstein	**Fighting Homelessness Through Services and Housing Act:** Similar to H.R. 1978, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to Committee on Health, Education, Labor, and Pensions	CalOptima: Watch
S. 2613 Harris	**Ending Homelessness Act of 2019:** Similar to H.R. 1856, would establish a federal grant program to appropriate $13 billion, beginning FY 2020 through FY 2024, to fund comprehensive homeless support services. Grant funds would be allocated to address the poverty rate, shortage of affordable housing, overcrowded housing, the number of individuals experiencing homelessness who are unsheltered, individuals experiencing chronic homelessness, and other issues related to homelessness in the United States. Of note, no less than 75% of grants allocated are to be used for permanent supportive housing, including capital costs, rental subsidies, and related services.	**10/16/2019** Introduced; Referred to the Committee on Baking, Housing and Urban Affairs	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 143 Quirk-Silva	**Homeless Shelter Crisis:** Extends existing law, AB 932 (2017), until January 1, 2023, allowing designated cities or counties to establish a shelter crisis that exempts the construction of a homeless shelter from the California Environmental Quality Act (CEQA). Adds to the list of designated municipalities the County of Alameda, the County of Orange, and the City of San Jose. Requires transition plans for permanent housing for participants within the operational plans of each shelter. Additionally, this exemption only applies to the construction of a homeless shelter owned by either a state agency, city, county, or government-owned land.	**09/26/2019** Signed into law **09/05/2019** Passed Senate floor **05/09/2019** Passed Assembly floor **12/13/2018** Introduced	CalOptima: Watch County of Orange: Support
AB 1199 Petrie-Norris	**Use of Fairview Developmental Center:** Requires a public hearing and public comments regarding the use of the Fairview Developmental Center in Costa Mesa, CA.	**10/12/2019** Signed into law **09/05/2019** Passed Senate floor **05/16/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch
SB 450 Umberg	**Motel Conversion for Supportive and Transitional Housing:** Exempts developers from following California Environmental Quality Act (CEQA) steps in order to expedite the development of motel rooms into supportive and transitional housing units.	**09/26/2019** Signed into law **09/09/2019** Passed Assembly floor **05/06/2019** Passed the Senate **02/21/2019** Introduced	CalOptima: Watch County of Orange: Support

MEDI-CAL MANAGED CARE PLAN OVERSIGHT

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1642 Wood	**Medi-Cal Managed Care Plans:** Requires Medi-Cal managed care plans (MCPs) to provide assistance with transportation services for long-distance medical appointments and scheduling for out-of-network providers that may be necessary due to network adequacy deficiencies. Broadens and clarifies the authority of the Department of Health Care Services (DHCS) to levy sanctions on both MCPs and Mental Health Plans.	**10/02/2019** Signed into law **09/04/2019** Passed Senate floor **05/29/2019** Passed Assembly floor **02/22/2019** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 503 Pan	**Subcontracts:** Would have required Medi-Cal managed care plans (MCPs) to conduct annual audits, with at least 10 percent being conducted as surprise audits, of subcontractors who perform delegated functions involving medical review and decision making. Would have required the Department of Health Care Services (DHCS) to establish an audit tool to be used by the MCP, beginning January 1, 2021. Audits of subcontractors would have begun no sooner than January 1, 2022 and would have required audit results to be reported to DHCS, including the identification of the subcontractor being audited. Additionally, if more than one MCP subcontract with the same subcontracted provider, those MCPs would have been able to conduct a joint audit.	**10/13/2019** Vetoed **09/09/2019** Passed Assembly floor **05/22/2019** Passed Senate **02/21/2019** Introduced	CalOptima: Watch

MEMBER MATERIALS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 318 Chu	**Materials for Medi-Cal Members:** Would have required Medi-Cal managed care plans' (MCPs) specific written health education and information materials to be reviewed through "field testing" to ensure all materials meet readability and suitability standards. Materials required for field testing were to include: "Enrollment and disenrollment forms and information, new member welcome packets, member handbooks, appointment notices and reminders, forms and information regarding grievance or complaint procedures and information regarding external review of plan decisions, and notices of action." Field testing could have been conducted internally by the MCP or by an external entity, but must be done by a native speaker of the language being reviewed. The findings of the field testing were to be reported to the Department of Health Care Services (DHCS). Additionally, would have required DHCS to establish a workgroup of advocates and MCPs to measure the readability of member-facing materials used by MCPs, such as the *Rights and Responsibilities Form and the Medi-Cal Request for Information Form.*	**10/13/2019** Vetoed **09/05/2019** Passed Senate floor **05/23/2019** Passed Assembly floor **01/30/2019** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose

PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
ACR 131 Petrie-Norris	**Programs of All-Inclusive Care for the Elderly (PACE) Month:** Assembly Concurrent Resolution that recognizes September 2019 as PACE Month in California.	**09/09/2019** Resolution adopted in the Senate **08/30/2019** Resolution adopted in the Assembly **08/19/2019** Introduced	CalOptima: Watch CalPACE: Support; Sponsor

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1128 Petrie-Norris	**Programs of All-Inclusive Care (PACE) Licensing:** Exempts a primary a care clinic, adult day health care center, or home health agency from the Department of Public Health (DPH) licensing requirements. Applies to agencies solely serving PACE participants, effective upon agreement of the Department of Health Care Services (DHCS), but no later than January 1, 2021. This will streamline the licensing process by having the clinic licensing, adult day services licensing, or home health licensing under the responsibility of DHCS. Additionally, authorizes a primary care clinic, adult day health care center, or home health agency to provide services to a Medi-Cal beneficiary during the PACE enrollment eligibility period, for no more than 60 days, when that center solely serves PACE participants.	**10/12/2019** Signed into law **09/10/2019** Passed Senate floor **05/28/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch CalPACE: Support; Sponsor

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 66 Atkins/ McGuire	**Federally Qualified Health Center (FQHC) Reimbursement:** Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that do not allow an FQHC to be reimbursed for a mental or dental and physical health visits on the same day. A patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit through the member's primary care provider and a mental health or dental visit as two separate visits, regardless if at the same location on the same day. As a result, the patient would no longer have to wait a 24-hour time period in order to receive medical and dental or mental health services, while ensuring that clinics are appropriately reimbursed for both services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**09/13/2019** Moved to inactive file; Two-year bill at the request of the author **08/30/2019** Passed Assembly Committee on Appropriations **05/23/2019** Passed Senate floor **01/08/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Support; Cosponsor

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4932 Thompson	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to S. 2741, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: • Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; • Remove geographic and originating site restrictions for services like mental health and emergency medical care; • Allow rural health clinics and other community-based health care centers to provide telehealth services; and • Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Committees on Energy and Commerce; Ways and Means	CalOptima: Watch AHIP: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 2741 Schatz	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to H.R. 4932, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: • Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; • Remove geographic and originating site restrictions for services like mental health and emergency medical care; • Allow rural health clinics and other community-based health care centers to provide telehealth services; and • Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Senate Committee on Finance	CalOptima: Watch AHIP: Support

*Information in this document is subject to change as bills are still going through the early stages of the legislative process.

ACAP: Association for Community Affiliated Plans
AHIP: America's Health Insurance Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: November 20, 2019

2019 Federal Legislative Dates

January 3	116th Congress convenes 1st session
April 15–26	Spring recess
July 29–September 6	Summer recess
September 30–October 11	Fall recess

2019 State Legislative Dates

January 7	Legislature reconvenes
February 22	Last day for legislation to be introduced
April 26	Last day for policy committees to hear and report bills to fiscal committees
May 3	Last day for policy committees to hear and report non-fiscal bills to the floor
May 17	Last day for fiscal committees to report fiscal bills to the floor
May 28–31	Floor session only
May 31	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 12–August 9	Summer recess
August 30	Last day for fiscal committees to report bills to the floor
September 3–13	Floor session only
September 13	Last day for bills to be passed. Final recess begins upon adjournment
October 13	Last day for Governor to sign or veto bills passed by the Legislature
December 2	Convening of the 2020–21 session

Sources: 2019 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan), and the Program of All-Inclusive Care for the Elderly (PACE).

Board of Directors Meeting
December 5, 2019

CalOptima Community Outreach Summary — November 2019

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Events Update

On Tuesday, October 29, 2019, Community Relations partnered with Quality Analytics to host a Mobile Mammogram event at CalOptima's satellite office at the County Community Service Center in Westminster. The purpose of the event was to ensure our members have good breast health and increase CalOptima's HEDIS measurement for breast cancer screenings.

Event invitations were mailed directly to approximately 900 CCN and COD members between the ages of 50 and 74 who live in Anaheim, Fountain Valley, Westminster, Midway City, Santa Ana, Garden Grove and Stanton and are due for a mammogram. Staff also conducted outreach calls to approximately 500 members to encourage participation. Transportation was coordinated for members who do not have access to transportation to attend the event.

Community Relations also partnered with Susan G. Komen and Southland Integrated to provide health education and resources on the day of the event. Southland Integrated also provided a nurse practitioner to conduct clinical breast exams and consultations. CalOptima's Population Health Management department provided a registered dietitian to conduct BMI measurements. As part of CalOptima's member incentive

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program, CCN and COD members who completed the mammogram and health screenings on the day of the event, also received a $25 gift card.

For additional information or questions, please contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities

As of October 30, 2019, CalOptima expected to participate in 44 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
11/01/19	• Covered Orange County General Meeting
11/04/19	• Orange Cunty Health Care Agency Mental Health Services Act Steering Committee Meeting • Fullerton Collaborative
11/05/19	• Alzheimer's Latino Conference Planning Meeting
11/07/19	• Continuum of Care Homeless Provider Forum • Refugee Forum of Orange County
11/08/19	• Orange County Diabetes Coalition • Senior Citizens Advisory Committee Meeting • Santa Ana Early Learning Initiative Meeting
11/12/19	• Orange County Cancer Coalition Meeting • San Clemente Youth Wellness and Prevention Coalition Meeting
11/13/19	• Orange County Communications Workgroup • Anaheim Homeless Collaborative Meeting • Orange County Strategic Plan for Aging – Healthcare Subcommittee Meeting
11/14/19	• Buena Park Collaborative • State Council on Developmental Disabilities Regional Advisory Committee Meeting • Aging and Disability Resource Connection Meeting
11/19/19	• North Orange County Senior Collaborative Meeting • Orange County Housing and Homeless Services Focus Group • Placentia Collaborative Meeting
11/20/19	• La Habra Community Collaborative Meeting

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11/21/19	• Garden Grove Community Collaborative Meeting • Kid Healthy Community Advisory Committee Meeting • Orange County Women's Health Project Advisory Board Meeting • Orange County Children's Partnership Committee Meeting
11/25/19	• Stanton Collaborative Meeting
11/26/19	• Orange County Senior Roundtable Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff/ Volunteer to Attend	Events/Meetings
11/01/19	2	• Day of the Dead hosted by City of Anaheim (Sponsorship Fee: $1,000 included one exhibit space and display agency's banner at the event site and mention of agency on main stage.
	1	• Resource Fair and Flu Clinic hosted by City of Tustin (Registration Fee: $25 included one resource table for outreach at the event.)
11/03/19	2	• Mental Health Awareness Walk hosted by Vietnamese American Mental Health Association (Sponsorship Fee: $500 included agency's name mentioned on television talk show and one resource table for outreach at the event.)
11/06/19	2	• Annual Resource Fair hosted by CHOC Children's Hospital
11/08/19	4	• 7th Annual OC Women's Health Summit OC Women's Health Project (Sponsorship Fee: $1,000 included logo recognition in print materials, website, newsletter, social media and signage, two tickets with preferred seating to film screening and summit, one table at summit for outreach.)
	2	• Senior Week Health and Wellness Fair hosted by Institute for Healthcare Advancement (Registration Fee: $150 ($75 for each program — PACE and OCC) included two tables for outreach at the event.)
	2	• Second Annual Resource Fair hosted by the Office of Assemblywoman Sharon Quirk-Silva
11/09/19	2	• Family Health Expo at Cal State Fullerton Center for Healthy Neighborhood hosted by Clinic in the Park
11/12/19	2	• Fall Conference and Annual Meeting hosted by California Association for Adult Day Services (Registration Fee: $850 included one table for outreach and two general conference admissions for representatives.)

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11/16/19	4	• Annual Alzheimer's Latino Conference hosted by Alzheimer's Orange County (Sponsorship Fee: $3,000 included opportunity to give a welcome presentation during opening ceremony, acknowledgement in press releases and advertisement one month prior to conference (radio, magazine, website and newspaper), agency logo prominently placed around conference, on agenda and in looping video, agency's information placed in goody bag, certificate of recognition, lunch for two staff and one resource table at the event.)
	2	• Witness to Mercy: Day of Service and Justice hosted by Diocese of Orange
11/17/19	2	• Community Health Fair held at Our Lady of La Vang Church hosted by St. Joseph Hospital
	1	• Meet on Beach hosted by City of Buena Park
	1	• Meet on Beach hosted by City of Anaheim
11/19/19	2	• Annual Meeting and Allied Conference hosted by California Association of Area Agencies on Aging (Registration Fee: $620 included one table for outreach and two general conference admissions.)
	2	• Community Resource and Health Fair hosted by Huntington Beach Adult School
11/22/19	2	• Community Health Fair at Vietnamese Catholic Center hosted by St. Joseph Hospital

As of October 30, 2019, CalOptima expected to organize or convene the following 15 community stakeholder events, meetings and presentations:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
11/05/19	• Community-Based Organization Presentation to Orange County Department of Education School Nurses — Topic: Medi-Cal in Orange County
11/06/19	• Community-Based Organization Presentation to Orange County Office on Aging — Topic: Medi-Cal in Orange County
11/15/19	• Community-Based Organization Presentation to Mercy House — Topic: CalOptima's Clinical Field Teams
11/19/19	• Orange County Health Care Agency — Seeking Safety Training
11/21/19	• CalOptima's Health Network Forum
11/27/19	• Cafecito: Latino Community Collaborative Meeting

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TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
11/01/19	• County Community Service Center Health Seminar — Topic: Mindfulness-Based Stress Reduction Overview (Vietnamese)
11/02/19	• OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Retention and Sales Event at Delhi Community Center
11/06/19	• County Community Service Center Health Seminar — Topic: Fall Prevention (Vietnamese) • CalOptima New Member Orientation for Medi-Cal Members at County Community Service Center (Vietnamese)
11/07/19	• County Community Service Center Health Seminar — Topic: OneCare Connect (Vietnamese)
11/08/19	• County Community Service Center Health Seminar — Topic: Mindfulness-Based Stress Reduction (Vietnamese)
11/20/19	• CalOptima New Member Orientation for Medi-Cal Members at County Community Service Center (Vietnamese)
11/21/19	• The Great American Smoke Out Event — Topic: Escape the Vape
11/22/19	• County Community Service Center Health Seminar — Topic: Mindfulness-Based Stress Reduction (Vietnamese)

CalOptima provided zero endorsements during this reporting period (e.g., letters of support, program/ public activity events with support or use of name/logo).

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CalOptima Board of Directors
Community Activities

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public activities, which meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

December

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Monday, 12/2 1-4pm	++OCHCA Mental Health Services Act Steering Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Delhi Center 505 E. Central Ave. Santa Ana

Monday, 12/2 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 12/3 8:30-11am	+OC Social Services Agency Trends in Elder Abuse Town Hall Event	Community Presentation Open to the Public	1 Staff	Tustin Area Senior Center 200 S. C St. Tustin
Tuesday, 12/3 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, 12/4 9-10:30am	++OC Aging Services Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's Orange County 2515 McCabe Way Irvine
Wednesday, 12/4 10am-2pm	++Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Family Justice Center 150 W. Vermont Anaheim
Wednesday, 12/4 10:30am-12pm	++OC Healthy Aging Initiative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's Orange County 2515 McCabe Way Irvine
Thursday 12/5 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 12/5 2:30-4:30pm	++OC Women's Health Project Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana

+ Exhibitor/Attendee
++ Meeting Attendee

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Friday, 12/6 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, 12/9 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
Tuesday, 12/10 9-10:30am	++OC Strategic Plan for Aging Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 12/10 10-11:30am	++OC Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Cancer Society 1940 E. Deere Ave. Santa Ana
Tuesday, 12/10 3:30-5:30pm	++San Clemente Youth Wellness and Prevention Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	189 Avenida La Cuesta San Clemente
Wednesday, 12/11 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 12/11 3:30-4:30pm	++OC Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 12/12 10-11am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park

Thursday, 12/12 11:30am-12:30pm	++Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 12/12 6:30-8:30pm	*CalOptima Workshop Transcending Principles of Street Medicine and Their Clinical Application	Workshop for Physicians and Licensed Health Care Professionals Registration required.	N/A	DoubleTree Hotel 100 The City Dr. Orange
Friday, 12/13 9:30-11am	++Senior Citizens Advisory Council Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Tuesday, 12/17 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, 12/18 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
Wednesday, 12/18 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, 12/18 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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Thursday, 12/19 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, 12/19 11:30am-12:30pm	++Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 12/19 1-2:30pm	++Surf City Senior Providers Network and Lunch	Steering Committee Meeting: Open to Collaborative Members	N/A	Senior Center in Central Park 18041 Goldenwest St. Huntington Beach
Thursday, 12/19 1-3pm	++Orange County Care Coordination for Kids Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Monday, 12/23 12:30-1:30pm	++Stanton Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton