NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, OCTOBER 1, 2020
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Doug Chaffee, Alternate

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

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

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

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

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

1) **Listen to the live audio at +1 (914) 614-3221 Access Code: 887-498-811 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/4458874103183811851**
3) **rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
CalOptima 25th Anniversary Celebration

MANAGEMENT REPORTS
1. Chief Executive Officer Report
   a. CalOptima's 25th Anniversary
   b. Intergovernmental Transfer 10 Funds
   c. All-Plan Meeting Medi-Cal Financial Topics
   d. Medicaid Fiscal Accountability Rule Withdrawal
   e. COVID-19 Status and Response
   f. Medi-Cal Rx Transition
   g. Medi-Cal 2020 Waiver Extension Request
   h. Whole Person Care Pilot
   i. OneCare Connect Transition
   j. Clinical Field Team Sustainability
   k. Medi-Cal Audit Findings
   l. CalOptima Speakers at Community Events
   m. Preventive Care Mailings

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.

INFORMATION ITEMS
2. Medi-Cal Pharmacy Carve Out

3. COVID-19 Update

4. Intergovernmental Transfer Overview

5. Strategic Plan Update

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

CONSENT CALENDAR
7. Minutes
   a. Approve Minutes of the September 3, 2020 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the May 20, 2020 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee: the May 21, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; and the August 13, 2020 Regular Meeting of the CalOptima Board of Directors' Provided Advisory Committee

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

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

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

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

12. Receive and File August 2020 Financial Summary

13. Receive and File Compliance Report

14. Receive and File Federal and State Legislative Advocates Reports

15. Receive and File CalOptima Community Outreach and Program Summary

REPORTS

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

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

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

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

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

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

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

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

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

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

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

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

28. Consider Approval of Modifications to Quality Improvement Polices

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

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

ADVISORY COMMITTEE UPDATES

31. Provider Advisory Committee Update

32. OneCare Connect Member Advisory Committee Update

33. Whole-Child Model Family Advisory Committee Update

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

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

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

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

ADJOURNMENT

How To Join The Webinar

Thu, Oct 1, 2020 2:00 PM - 6:00 PM PDT

Add to Calendar: Outlook® Calendar | Google Calendar™ | iCal®

1. Please register for Regular Meeting of the CalOptima Board of Directors on Oct 1, 2020 2:00 PM PDT at:

https://attendee.gotowebinar.com/register/4458874103183811851

Note: This link should not be shared with others; it is unique to you.

Before joining, be sure to check system requirements to avoid any connection issues.

2. Choose one of the following audio options:

TO USE YOUR COMPUTER'S AUDIO:
When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.

--OR--

TO USE YOUR TELEPHONE:
If you prefer to use your phone, you must select "Use Telephone" after joining the webinar and call in using the numbers below.
United States: +1 (914) 614-3221
Access Code: 887-498-811
Audio PIN: Shown after joining the webinar

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25th Anniversary Celebration

Board of Directors Meeting

October 1, 2020

Supervisor Andrew Do, Chair of the CalOptima Board of Directors and Vice Chair of the Orange County Board of Supervisors

Richard Sanchez, Interim Chief Executive Officer

Ladan Khamseh, Chief Operating Officer

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Happy Anniversary!



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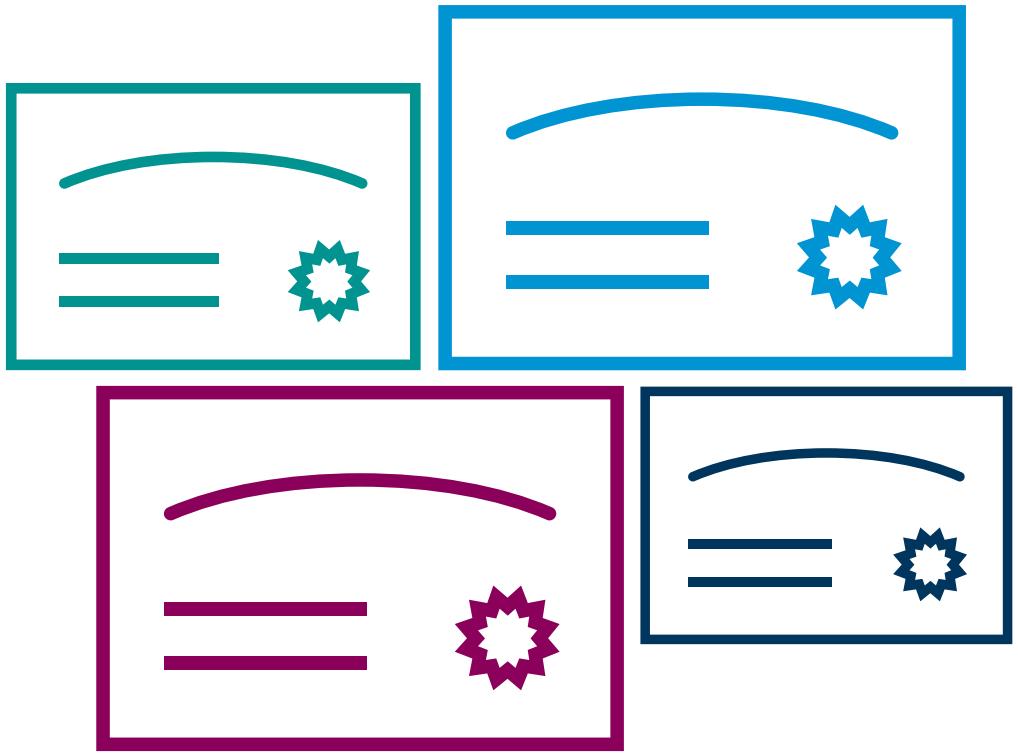
Recognitions and Resolutions

- Thank you to our Orange County Board of Supervisors and elected officials for recognizing CalOptima's anniversary



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Grateful for Provider Partnerships





























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Grateful for Community Partnerships

























































Depression and Bipolar Support Alliance
Orange County CA Chapter







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CalOptima Then and Now

	1995	2020
Membership	180,000	767,745
Programs	Medi-Cal	Medi-Cal OneCare OneCare Connect MSSP PACE
Threshold Languages	English, Spanish and Vietnamese	English, Spanish, Vietnamese, Farsi, Korean, Arabic and Chinese
Employees	44	1,379
Annual Revenue	$188 million	$3.6 billion

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CalOptima Milestones (1995–2008)

1995 — CalOptima launches with 180,000 Medi-Cal members



1996 — CalOptima expands to include long-term care members, seniors, people with disabilities and dual eligible members



1998 — CalOptima launches Healthy Families Program

2001 — CalOptima launches Multipurpose Senior Services Program (MSSP)

2005 — CalOptima launches OneCare (HMO SNP)

2008 — CalOptima launches Aging & Disability Resource Connection

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CalOptima Milestones (2012–15)

2012

CalOptima Medi-Cal receives NCQA Commendable Accreditation

2013

CalOptima launches Program of All-Inclusive Care for the Elderly

PACE CalOptima A Public Agency Better. Together.

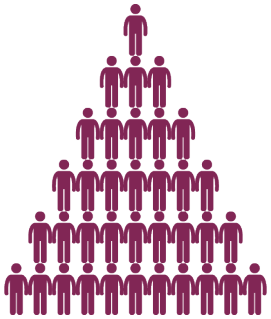
2014

NCQA rates CalOptima as a top-quality Medi-Cal plan in California (2014–2020)

CalOptima Community Network launches to increase access to care

OneCare Connect CalOptima A Public Agency Better. Together.

2015



CalOptima reaches 750,000 members

CalOptima launches OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

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CalOptima Milestones (2018–20)

CalOptima begins direct administration of behavioral health benefits for Medi-Cal members



CalOptima launches the Whole-Child Model to integrate California Children's Services



CalOptima begins direct administration of behavioral health benefits for OneCare and OneCare Connect members

2018 2019 2020

CalOptima dedicates $100 million to Homeless Health Initiatives



CalOptima PACE earns highest satisfaction rating among California PACE organizations

CalOptima responds to COVID-19 pandemic and prepares for membership growth



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Congratulations 25-Year Employees!



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Our Mission

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

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MEMORANDUM

DATE:	September 23, 2020
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Interim CEO
SUBJECT:	CEO Report — October 1, 2020, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

CalOptima Recognizes 25 Years of Service to Orange County
Starting in October, CalOptima will recognize our 25th anniversary and roots as a local solution to improve access to quality health care services for low-income Orange County residents. As a public agency, CalOptima has always worked in partnership with private health networks, connecting members with thousands of providers in a unique public-private health care system. Across 25 years, CalOptima has grown from 180,000 members to nearly 768,000 members. To celebrate CalOptima's anniversary and our ongoing collaborative partnerships, the October 1 Board meeting will include a presentation reflecting on major milestones and expressing appreciation to stakeholders. Separately, CalOptima will implement a special logo on various communications for the anniversary year and honor employees for their contribution to the agency's success at an October 21 All Hands meeting.

Intergovernmental Transfer (IGT) 10 Funds May Bridge Proposed Rate Reductions
For the past few months, CalOptima has been making the provider community aware of possible rate adjustments in January 2021 by the Department of Health Care Services (DHCS) for Medi-Cal Expansion and Managed Long-Term Services and Supports. At the same time, we have shared that we are pursuing ways to mitigate the impact of any changes. Staff is now evaluating the option to use IGT 10 dollars to address the funding shortfalls. CalOptima anticipates receipt of approximately $66 million in IGT 10 funds during Spring and Fall 2021. IGT 10 covers an 18-month period from July 1, 2019, through December 31, 2020. The use of the funds is limited to covering Medi-Cal benefits for existing CalOptima members. As of today, CalOptima does not have final details on the rate reductions. The use of IGT 10 funds to create a glidepath to lower rates would protect health networks and providers from experiencing an unanticipated sharp decline in their capitation and give providers time to make operational changes.

All-Plan Meeting Reviews Key Changes Affecting Medi-Cal Financial Topics
On September 9, CalOptima Chief Financial Officer Nancy Huang and I participated in DHCS' CEO/CFO All-Plan Meeting, which provided updates regarding the new rate release timeline and managed care rate adjustments. DHCS is switching from a Fiscal Year to Calendar Year model for rates, starting January 2021. As such, the regulator shared the new timetable.

- *September 2020:* Release draft Medi-Cal base rates
- *October 2020:* Release draft Coordinated Care Initiative dual rates (Medi-Cal and OneCare Connect) and Health Homes Program rates
- *December 2020:* Release final rates

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Separately, as part of state budget reductions, DHCS will implement certain efficiency and plan level adjustments, effective January 1, 2021, that focus on, for example, avoidable emergency room visits and population acuity. CalOptima is analyzing the financial impact of the various proposals on providers. Information about the topics at the CEO/CFO meeting was shared at the September 17 Health Network Forum.

Federal Regulator Withdraws Medicaid Fiscal Accountability Rule (MFAR)
On September 14, Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma announced the withdrawal of MFAR. Released in late 2019, MFAR had proposed to overhaul how states use supplemental payments in Medicaid to draw additional federal funds, but the proposal was opposed by a diverse range of stakeholders. The change would have impacted Medicaid-funded programs, including CalOptima's IGT transactions. Reflecting health plans' unified stance, Local Health Plans of California, California Association of Health Plans, Association for Community Affiliated Plans and America's Health Insurance Plans had submitted strong comments against proposal. Further, governors also criticized MRAR, arguing it jeopardized Medicaid funding when states are already facing severe pandemic-related economic pressures.

Orange County in California's Red Tier, CalOptima Response Continues
Based on improving COVID-19 case and testing positivity rates, Orange County moved from Purple Tier (Widespread Risk) to the Red Tier (Substantial Risk) of California's Blueprint for a Safer Economy on September 8. Orange County currently meets the case and positivity requirements for the Orange Tier (Moderate Risk) and will advance to that tier after a minimum of three weeks in the Red Tier, if it continues to meet the requirements for the Orange Tier for a minimum of two weeks. From our first case until September 22, CalOptima has reported 3,018 positive cases, 1,677 hospitalizations and 293 deaths. Below are updates in areas of pandemic response and outreach.

- *Infection Prevention in Nursing Homes:* UC Irvine, the Orange County Health Care Agency (OCHCA) and CalOptima jointly launched the Orange County Nursing Home COVID-19 Infection Prevention Program on June 1, and adoption has been strong. The program offers either intensive, in-person training or access to an online toolkit. On September 11, 60 nursing home leaders attended a CalOptima-hosted webinar to share best practices in using personal protective equipment. Shruti Gohil, M.D., MPH, assistant professor in the UCI School of Medicine Division of Infectious Diseases, presented the information. On September 21, UCI published an article about the infection prevention initiatives and its partnership with CalOptima.
- *Mental Health Op-Ed:* Kids' mental health during COVID-19 is a topic of great interest, and CalOptima's Communications team worked with Edwin Poon, Ph.D., director of Behavioral Health Services, to write and place an op-ed article in the digital version of the Orange County Register in September. View the article here.
- *Radio Program:* CalOptima and OCHCA partnered to speak about behavioral health on the Angels Radio (KLAA-AM 830) Community Cares program. Dr. Poon and Bhuvana Rao, Ph.D., OCHCA program manager II, Children, Youth & Prevention Behavioral Health Services, focused on children's needs during COVID-19, the impact of toxic stress, local mental health resources and other topics. The program will air October 4 at 5:30 a.m. and 10:30 p.m.

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As January 2021 Transition to Medi-Cal Rx Approaches, Draft Guidance Released
On September 2, DHCS held a Medi-Cal Rx webinar to share updates regarding the transition to a fee-for-service pharmacy delivery system. The regulator announced that the project is on time in meeting deliverables, thus no change to the January 1, 2021, launch is anticipated. DHCS released its draft All Plan Letter, and managed care plans have until September 30 to review and comment on the document that will provide considerable operational guidance. CalOptima's Business Integration team is coordinating the collection of feedback from the many affected departments across the agency. DHCS also released proposed call scripts for managed care plans to use when answering members' questions. As requested, staff will provide an update on the Medi-Cal Rx transition at your October 1 Board meeting.

DHCS Submits Request to Extend Medi-Cal 2020 Waiver for One Year
On September 16, DHCS submitted a request to CMS for a 12-month extension of California's Section 1115 Medicaid waiver, known as Medi-Cal 2020. Much of the current Medi-Cal program operates under this federal waiver. If approved, the extension would delay expiration from December 31, 2020, until December 31, 2021. DHCS considered stakeholder feedback before making its submission, and CMS will soon begin a 30-day federal public comment period.

CalOptima and County Prepare Contingency for Whole Person Care (WPC) Pilot
CMS and DHCS authorized the WPC pilot as part of the Medi-Cal 2020 waiver, which is nearing expiration as explained above. OCHCA is the lead agency for the local WPC pilot, which focuses on Medi-Cal members experiencing homelessness. CalOptima entered into an agreement with OCHCA to provide administrative support for WPC, including project management, data and reporting, and a personal care coordinator. Additionally, CalOptima made a grant with IGT funds to OCHCA to share the cost of recuperative care stays. In anticipation of the waiver expiration, the state had plans to incorporate parts of WPC into its California Advancing and Innovating Medi-Cal (CalAIM) initiatives, but CalAIM is now postponed indefinitely due to the pandemic. While CMS and DHCS are discussing a possible extension for WPC, the outlook is uncertain. CalOptima and OCHCA are collaborating on contingency planning and options for continued administrative support and recuperative care if the regulators do not extend and fund WPC by the end of 2020.

OneCare Connect Transition Planning to Begin With Stakeholder Engagement
OneCare Connect is a Cal MediConnect Plan that combines Medicare and Medi-Cal benefits into one health plan. Since OneCare Connect launched as a pilot program on July 1, 2015, it has been extended over the years by both state and federal authority; however, it is currently scheduled to end on December 31, 2022. Initially, the state planned to transition OneCare Connect members into OneCare (CalOptima's Dual Eligible Special Needs Plan) via CalAIM, but that proposal is postponed indefinitely due to the pandemic. Given the importance of planning ahead for any future transition, CalOptima will begin to engage stakeholders to consider the impact on members and providers should OneCare Connect not be extended past December 31, 2022.

Clinical Field Team (CFT) Sustainability a Priority in Transition to Permanent Program
Launched in April 2019, CalOptima's CFT pilot program contracts with community health centers to provide on-call urgent care services where individuals experiencing homelessness are. The centers also schedule days to provide primary and preventive services in mobile units at shelters and hotspots (e.g., soup kitchens, encampments, etc.). The pilot currently has an end date

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of December 31, 2020. CalOptima is aware of the dramatic changes throughout the county due to COVID-19, such as the expansion of telehealth as well as increased shelter options. We anticipate that the landscape will continue to change with the pandemic. To develop a sustainable CFT program, CalOptima may need to pursue an extension to allow more time to assess conditions under this "new normal," and future changes would come to your Board for consideration.

CalOptima Responds to Medi-Cal Audit Findings

DHCS' on-site audit of CalOptima Medi-Cal and Medicaid-based services for OneCare Connect took place January 27–February 7, 2020. DHCS reviewed an array of documents and data and conducted interviews with CalOptima staff as well as with a DHCS-selected delegate, Monarch HealthCare. On August 11, DHCS provided CalOptima with a final audit report that identified seven findings in the Medi-Cal areas of Access and Availability of Care and Member's Rights. CalOptima did not receive any findings for State-Supported Services or OneCare Connect. On September 11, CalOptima's Office of Compliance submitted a Corrective Action Plan to DHCS and has begun remediating the deficiencies.

CalOptima Speakers Featured at Community Events

As a community-based health plan, CalOptima prioritizes engagement with local efforts that support Orange County and provider partnerships. Below are two current examples of participation with other leading organizations.

- *Orange County Community Indicators Report and Panel:* CalOptima is one of several sponsors of the annual Orange County Community Indicators Report, which includes local health status information. This year's report features a special section dedicated to the impact of COVID-19, and CalOptima contributed information regarding our member and provider experiences. The report debuted on September 22 during a virtual panel discussion, led by Dr. Wallace Walrod, Chief Economic Advisor for Orange County Business Council, and I participated as one of the speakers.
- *CHOC Mental Health Webinar:* CalOptima is a sponsor of CHOC's Mental Health Live Webinar, "Compassion Fatigue/Vicarious Trauma for the Provider," on October 2–3. Three executives will participate: Chief Medical Officer David Ramirez, M.D., will provide opening remarks both days, Dr. Poon will discuss Medi-Cal services and children's mental health during COVID-19, and Betsy Ha, RN, Executive Director, Quality & Population Health Management, will offer a Continuing Medical Education session about mindfulness for providers. Attendees will be physicians, mental health providers, school nurses and school counselors.

Mailings Reach Out to Members to Promote Preventive Care

This month, CalOptima's Population Health Management team is outreaching to members with incentives to obtain preventive services. CalOptima mailed notices to more than 66,300 female members ages 21–64 who may be due for a cervical cancer screening and more than 19,200 female members ages 50–64 who may be due for a breast cancer screening. Further, more than 20,500 Medi-Cal members who have diabetes also received mailings offering incentives for them to have a diabetes A1c test and eye exam.

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Medi-Cal Pharmacy Carve Out (Medi-Cal Rx)

Board of Directors Meeting

October 1, 2020

Emily Fonda, MD, MMM, CHCQM
Deputy Chief Medical Officer
Kris Gericke, Pharm.D.
Director, Pharmacy Management

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Background

- Executive Order (EO) N-01-19 : Effective January 1, 2021, DHCS is “carving out” the pharmacy benefit for more than 11 million Medi-Cal beneficiaries from managed-care plans and moving it to the fee-for-service (FFS) program
- Only applies to Medi-Cal program (OC/OCC/PACE are not affected)
- “Medi-Cal Rx” is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the FFS delivery system
- DHCS has stated there will be no change to the January 1, 2021, Medi-Cal Rx implementation date

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Medi-Cal Rx

- The State of California selected a Pharmacy Benefit Manager (PBM) vendor to administer the new pharmacy program
  - Magellan Rx
- Effective January 1, 2021, CalOptima Medi-Cal outpatient pharmacy claims will be processed through Magellan Rx instead of MedImpact (current PBM), and providers will have to follow the state “formulary” or Contract Drug List (CDL)
- MedImpact will be retained for OC/OCC/PACE

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Medi-Cal Rx (cont.)

- Many Medi-Cal Rx operational details are currently not yet finalized by an All Plan Letter (APL):
  - Grievance process
  - Transition policy
  - Scope of coverage
  - Plan-retained responsibilities

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Medi-Cal Rx (cont.)

- Medi-Cal activities covered by the new program include:
  - Claims processing for all pharmacy services billed by pharmacies through Magellan Rx:
    - Medications
    - Enteral nutrition products
    - Some medical supplies
  - Pharmacy cross-over claims
  - Pharmacy network administration
  - Pharmacy drug rebate administration
  - Prior authorizations
  - Customer Service (beneficiaries and providers)
  - Health plan coordination activities (Magellan Rx liaison)

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Medi-Cal Rx (cont.)

- CalOptima retained Medi-Cal responsibilities:
  - Member care coordination as defined by DHCS (includes interaction with Magellan liaison)
  - Oversee clinical aspects of pharmacy adherence
  - Provide disease and medication management
  - Processing and payment of all medications and supplies billed on medical and institutional claims (Physician Administered Drugs, such as chemotherapy)
  - Participation on the Medi-Cal Global Drug Utilization Review (DUR) Board and other DHCS pharmacy committees
  - All PACE and OneCare Connect Medi-Cal pharmacy benefits
  - Others to be determined (DHCS All Plan Letter pending)

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Medi-Cal Rx Benefits

- Potential financial savings to the State of California
  - Lower administrative costs
  - Consolidate drug purchasing power
  - Strengthen California's ability to negotiate state supplemental drug rebates with drug manufacturers
- Standard pharmacy benefit across the state
- Modernize many existing DHCS pharmacy support systems
- Pharmacy network that includes the majority of the state's pharmacies

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Medi-Cal Rx Risks

- 180-day transition period benefit may suddenly create high TAR (PA)* volume when it ends with medication delays
- Lack of timely and complete pharmacy data for plans (2-day lag time for Medication Review Tool)
- Negative impact on care coordination
- Confusion for members and providers
- Magellan training website is not yet fully operational.
- APL is not finalized

* Treatment Authorization Request/Prior Authorization

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Medi-Cal Rx Risks (cont.)

- Unknown quality of customer service
- Decrease in plan quality scores
- Net financial savings are not guaranteed to materialize
  - Higher administrative costs
  - Ability to drive market share for preferred drug use?
  - Supplemental rebates may not offset program costs

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Medi-Cal Rx Risks (cont.)

- Limited state Contract Drug List (formulary) requires a TAR (PA) for a number of common medications for which CalOptima did not require authorization
- TAR (PA) required for many common pediatric medications that do not currently require prior authorization from CalOptima

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Medi-Cal Rx Outstanding Issues

- Pharmacy-related Customer Service call process
  - If members have medication access issues after contacting Magellan Rx, Customer Service staff will triage cases to CalOptima Pharmacy Management to assist
  - CalOptima Pharmacy Management staff will contact providers, pharmacies and/or the Magellan Rx liaison to resolve issues
- CalOptima Pharmacy Management staff will have limited access to the Magellan Rx claims system and will not be able to perform overrides (e.g., hospital discharge)
- Member grievance process related to pharmacy access issues has not been finalized

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Medi-Cal Rx Outstanding Issues

- Whole-Child Model
  - Potential disruption to medication access for these medically fragile children due to this transition
  - Standard PBM prior authorization criteria and processes do not adequately address the unique needs of these children with serious medical conditions. (CalOptima had a special process with MedImpact to accommodate these children.)
  - Many suspension/liquid formulations and other common CCS medications are not on the CDL
  - CalOptima Pharmacy Management staff are working with CHOC management to propose changes to medication coverage post-carve out to DHCS — ongoing process
- Plan-retained clinical responsibilities have not been defined (pending All Plan Letter)

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Communication and Training: Members

- Members will receive three mailings
  - 90- and 60-day from DHCS
  - 30-day from CalOptima
- Members will receive 30-day phone calls from CalOptima
- Magellan Rx will not open their call center until January 1, 2021
- CalOptima Customer Service will be responsible for answering all calls regarding the carve out before January 1, 2021
- After the final APL draft with CS instructions, a script will be created for members who may call CalOptima first and get referred to Magellan

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Communication and Training: Providers

- Pharmacies will receive three mailings from DHCS (90-, 60- and 30-day)
- Providers can register for the DHCS Medi-Cal Rx Subscription Service (MCRxSS) for email updates:
  - https://mcrxsspages.dhcs.ca.gov/Medi-CalRxDHCScagov-Subscription-Sign-Up
- DHCS will provide training materials for Medi-Cal providers starting in September via the Magellan Medi-Cal Rx website:
  - https://medi-calrx.dhcs.ca.gov/home/

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Communication and Training: CalOptima

- A CalOptima Multi-Departmental Workgroup has been regularly meeting since December 2019 to coordinate activities related to the carve out
- CalOptima began sending out communications to health networks and providers in July 2020
- CalOptima included presentations about the carve out in Health Network Forums and other meetings (WCM-CAC, WCM-FAC, PAC, MAC, QIC)
- CalOptima staff continue to participate in Medi-Cal Rx stakeholder meetings
  - LHPC
  - CAHP
  - DHCS meetings and forums

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Our Mission

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

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COVID-19 Update

Board of Directors Meeting

October 1, 2020

David Ramirez, M.D., Chief Medical Officer

Emily Fonda, M.D., Deputy Chief Medical Officer

Miles Masatsugu, M.D., Medical Director

Brigette Gibb, Executive Director of Human Resources

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Clinical Update

David Ramirez, M.D., Chief Medical Officer
Emily Fonda, M.D., Deputy Chief Medical Officer
Miles Masatsugu, M.D., Medical Director

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COVID-19 Impact in Orange County

- Significant short- and long-term impact locally
  - Continued social distancing efforts
  - Decreased but continued spread of the virus in the community
  - Vulnerable populations continue to be impacted disproportionately
- Expanded testing
  - Multiple options have been implemented throughout Orange County
  - Delays in testing turnaround times are an ongoing challenge
- Economic impact
  - Anticipated increase in Medi-Cal and CalOptima membership
  - State budget revision

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Initial COVID-19 Impact on CalOptima

Member Experience

- Cancelling appointments because they are afraid to go out
- Requesting locations of testing sites
- Asking about coverage for COVID-19
- Complaining that their providers do not have testing available
- Complaining their providers won't see them due to COVID-19 outbreak
- Inquiring about providers who do telehealth visits due to anxiety of going in person
- Experiencing delays in care due to adjusted hours, rescheduled or cancelled appointments, e.g., not able to obtain durable medical equipment or medications, and not able to access provider, etc.

Provider Experience

- Changing hours, consolidating services and sites
- Cancelling elective surgeries and procedures
- Changing to phone consultations/telehealth
- Experiencing confusion about testing sites and current testing strategy
- Enrolling in Medi-Cal (new providers) under emergency Department of Health Care Services (DHCS) process and seeing members at Medi-Cal rates
- Dealing with Provider Facility Site Reviews temporarily on hold due to COVID-19, impacting credentialing and triannual reviews

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CalOptima COVID-19 Response

- CalOptima Board Actions
  - April
    - Allocated funds for staff transition to temporarily telework
    - Increased health network capitation by 5%, April through June
    - Approved modified policies to support ongoing Community-Based Adult Services (CBAS) operations
    - Approved telehealth policy to align with regulatory changes and increase care options
    - Ratified contracts with virtual care expert and medical consultants
    - Approved program modifications: Homeless Clinic Access Program and Clinical Field Teams
    - Expanded the Post-Acute Infection Prevention Quality Initiative
    - Authorized unbudgeted expenditures for emergency purchases of personal protective equipment (PPE)

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CalOptima COVID-19 Response (cont.)

- CalOptima Board Actions (cont.)
  - May
    - Authorized funding to support Orange County Nursing Home COVID-19 Infection Prevention Team program in partnership with UC Irvine and Orange County Health Care Agency
    - Approved Virtual Care Strategy and Roadmap to include texting and eConsult vendors
    - Approved funding and contracting for PACE Without Walls
    - Authorized modifications to CalOptima's participation in and funding for community events, due to the pandemic

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CalOptima COVID-19 Response (cont.)

- CalOptima Board Actions (cont.)
  - June
    - Approved FY 2020–21 Budget that protects providers from 1.5% rate cut by the Department of Health Care Services (DHCS)
    - Authorized modification to Intergovernmental Transfer (IGT) grant agreements in response to the pandemic
    - Approved reimbursement of employee expenses for temporary telework
  - August
    - Ratify temporary operational changes at PACE regarding skilled home health services

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CalOptima COVID-19 Response (cont.)

- Operational changes
  - Formed an internal CalOptima COVID-19 response team
  - Coordinated response with county public health officials
  - Executed communication plan to reach all stakeholders
  - Changed pharmacy rules to address members' needs
  - Conducted educational outreach
    - Member call campaign
    - Educational videos
  - Expanded Behavioral Health support, with 24/7 call line, telehealth options, trauma-informed care training and care coordination
  - Implemented multiple COVID-19 tracking and reporting efforts to enhance measurement and analysis

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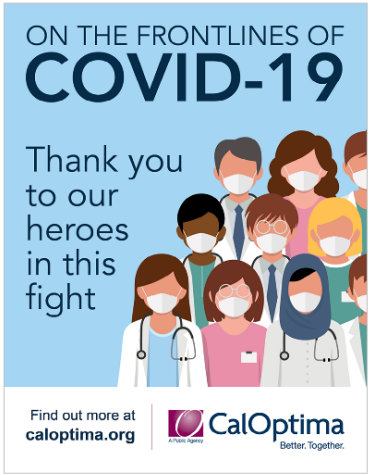
COVID-19 Community Awareness Campaign

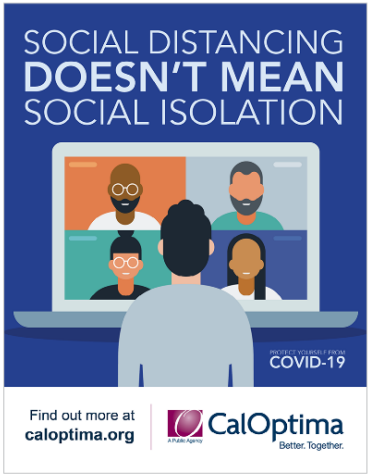












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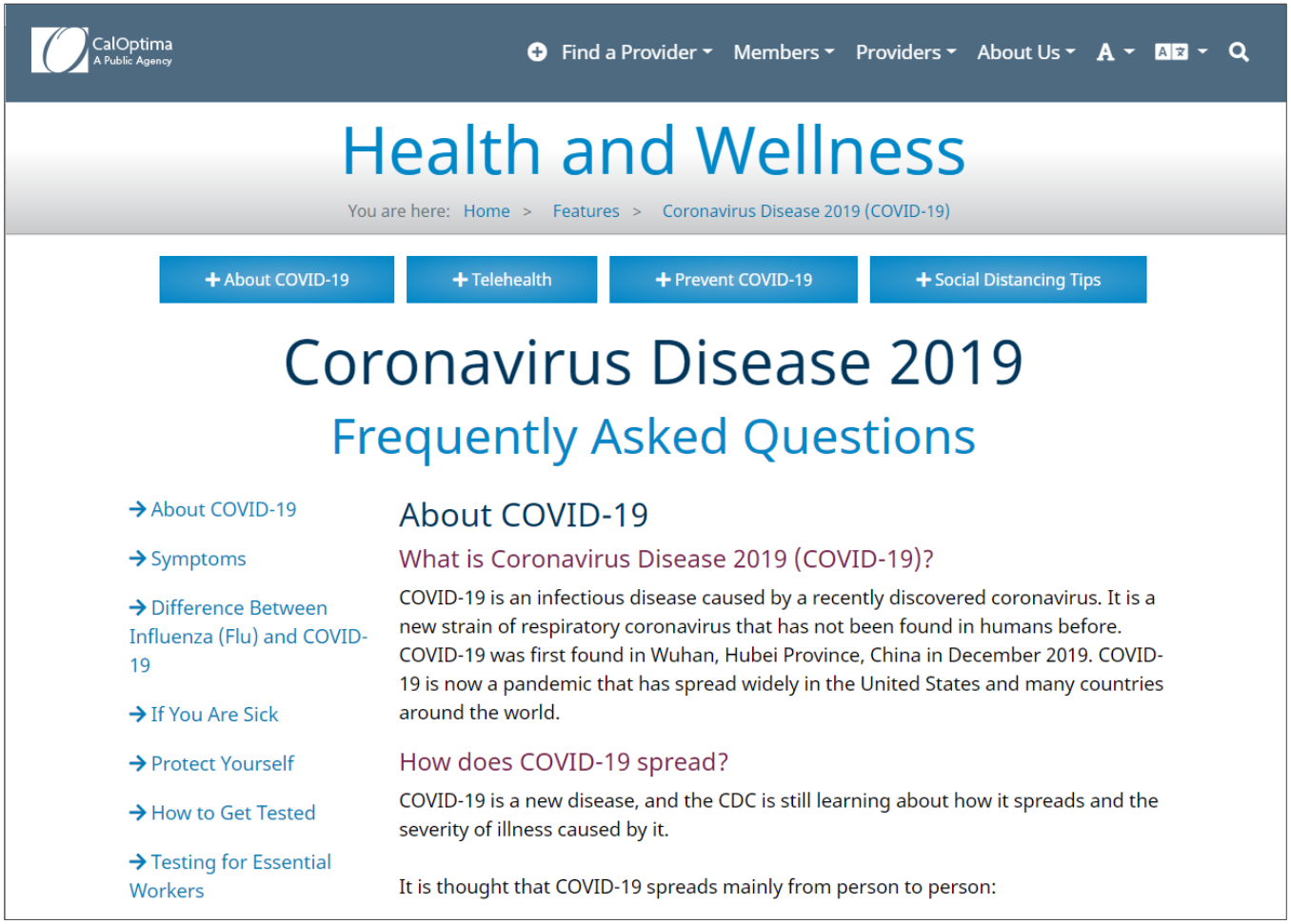
Member Web Page



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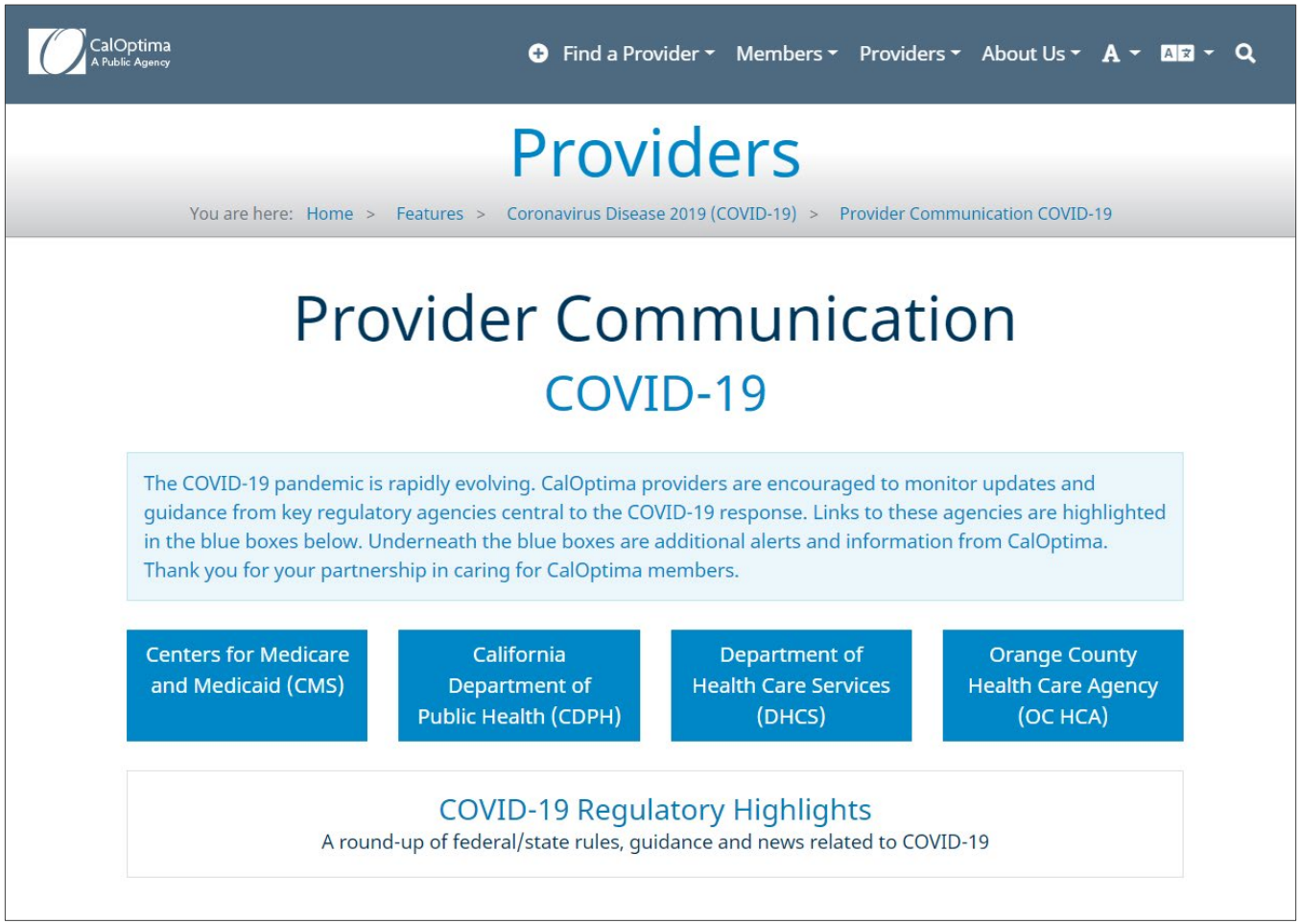
Provider Web Page



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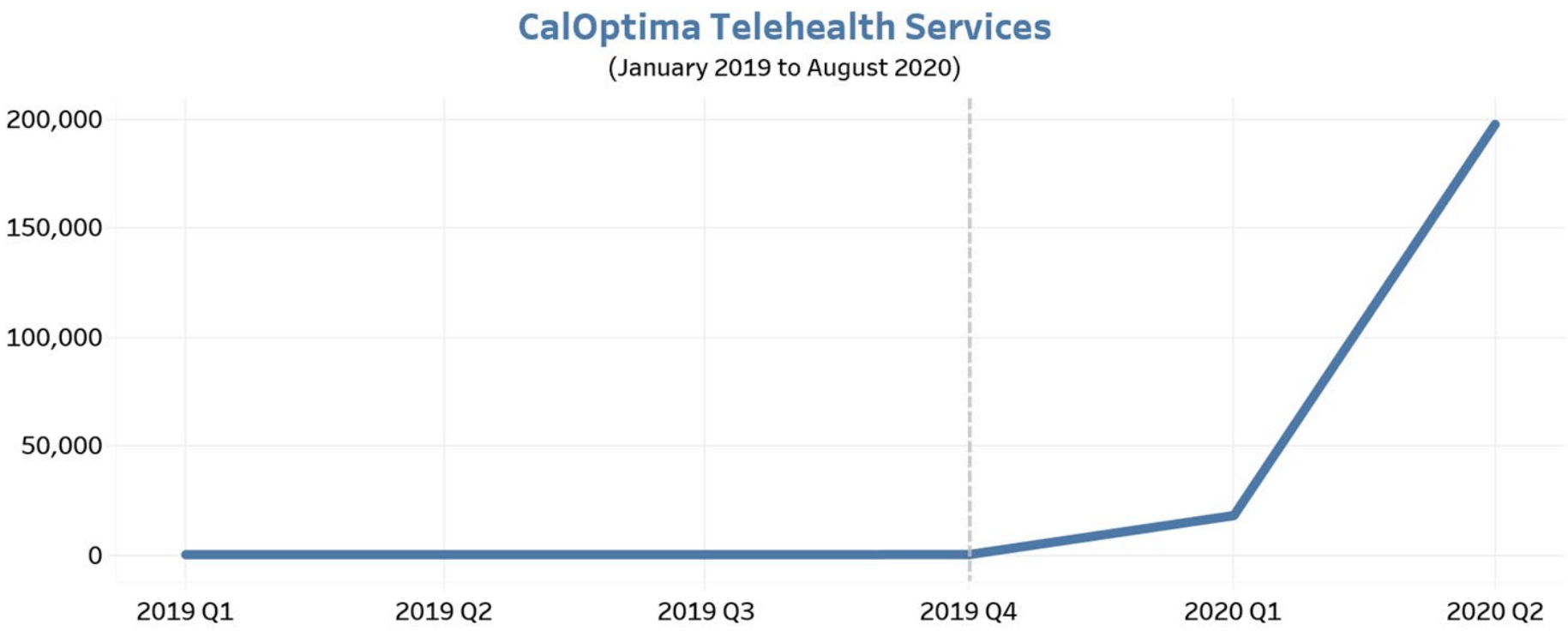
CalOptima Telehealth Services



Note: Based on claims and encounters received for full quarters

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Financial Support During COVID-19

Provider Type	Action
Health Networks	Pay up to $14 million, via 5% Medi-Cal capitation increase, from April to June 2020
Hospitals	Expedited more than $300 million in supplemental payments, including Hospital Quality Assurance Fee, directed payments and IGTs
Skilled Nursing Facilities	Approved 20% rate increase, totaling $1.6 million per year; expanded existing Post-Acute Infection Prevention Quality Incentive, adding $3.4 million for three years; and partnered with UC Irvine and Orange County Health Care Agency on COVID-19 infection prevention program, with $629,000 in funding
Community-Based Adult Services (CBAS)	Expanded covered services to include telehealth, meal delivery and other out-of-center services

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Orange County Nursing Home COVID-19 Infection Prevention Team

- CalOptima approved more than $629,000 for a comprehensive infection control training program in partnership with UC Irvine and the Orange County Health Care Agency
- Program launched June 1
  - All CalOptima-contracted nursing homes may participate and access the online toolkit
    - Videos and printable info available at www.ucihealth.org/stopcovid
  - 10 nursing homes have volunteered for intensive in-person training and video monitoring
- Goal is to boost the cultural change needed in an environment where there are multiple residents in a room, shared surfaces and limited social distancing

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Post-Acute Infection Prevention Quality Initiative (PIPQI)

- PIPQI supports the use of chlorhexidine (CHG) soap in place of regular liquid soap for bathing
  - Goal is to reduce the presence of multidrug resistant organisms, such as MRSA that are highly prevalent (up to 88%) on the skin of nursing home patients
- CalOptima recently increased funding and incentives to support the CHG protocol
  - An added benefit is that coronaviruses, such as COVID-19, are highly sensitive to CHG

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PACE Without Walls

- PACE Operations (facility-based to community-based)
  - Closed PACE center to all visitors; launched at-home model
  - Transitioned 76% of staff to telework
  - Secured PPE with active inventory management
  - Conducting daily screening of all on-site staff
  - Using mobile phlebotomy and imaging
- Wellness Calls
  - More than 11,000 calls since PACE Without Walls started
    - Calls range from 2–40 minutes
    - Calls serve as an important social outlet for participants and a way to monitor their wellbeing
  - Calls are conducted by nurses, personal care attendants, social workers and rehab therapists

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PACE Without Walls (cont.)







- Care Package Delivery
  - More than 1,500 care packages delivered to date, including toilet paper, activities, masks, cards and notes of support from the PACE team
  - PACE vans are taking participants grocery shopping and to drive-thru food banks, while contracted partners deliver prepared meals

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PACE Without Walls (cont.)

- On-Site Clinic
  - PACE clinic remains open for visits that cannot be done using telehealth
- Drive-Thru Clinics
  - For immunizations and other needs
- Virtual Care
  - PACE clinicians using tablets and cell phones to engage participants virtually
- Home-Based Services
  - Increase in provider home evaluations
  - Increase in skilled services provided in the home



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Next Steps

- Continue to coordinate response with the county health care agency
- Continue to monitor and follow county and state public health guidance
- Communicate any updates and changes to members, providers, health networks, staff and all other stakeholders

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Temporary Telework Update

Brigette Gibb, Executive Director of Human Resources

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COVID-19 and Temporary Telework

- In response to stay-at-home orders, social distancing requirements and other guidance intended to mitigate the spread of the coronavirus, CalOptima quickly but methodically deployed most of the workforce for temporary telework by April 2020

Work Location	Number of Employees	Totals
PACE	27	160
505 Building	133	
Temporary Telework	721	1,168
Regular Telework*	447	

*The maximum number of authorized regular teleworkers is 30% of approved full-time equivalent (FTE) positions. For FY 2020–21, the maximum is 449.

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Regular Telework Program

- Prior to the COVID-19 pandemic, CalOptima had a longstanding telework program, which is formalized in Policy GA.8044 – Telework Program

- Temporary teleworkers signed a temporary telework agreement that required them to adhere to the provisions of Policy GA.8044

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Telework Program Policy

- Among other provisions, Policy GA.8044 includes:
  - How telework positions are identified
  - Employee eligibility
  - Home office criteria
  - Adherence to CalOptima policies, rules, practices and more
  - Work schedule and accessibility requirements
  - Pre-deployment orientation requirements
  - Handling protected health information (PHI)
  - Performance management and monitoring

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Supporting Temporary Telework

- To support newly teleworking employees and their supervisors, Human Resources collaborated with other internal departments to:
  - Host *Engaging a Remote Workforce* webinar
  - Provide protected leave and/or ADA accommodations
  - Launch mandatory ergonomics (office environment) training
  - Develop four telework resource guides
    - Maintaining a Healthy Workspace Environment
    - What is Ergonomics?
    - Virtual Meeting Etiquette 101
    - Make Working From Home Work

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Supporting Temporary Telework (cont.)

- Establish monthly performance metrics and monitoring
- Share performance monitoring expectations with employees and leaders
- Begin completing workstation assessments and home checklists with all temporary teleworkers
- Fill the regular teleworker program to capacity (final deployment is scheduled for October)

- This month, CalOptima is conducting midyear reviews of every employee's performance, which will provide an opportunity for performance feedback and discussion after approximately six months of telework for most employees

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Continuing Temporary Telework

- While the pandemic is ongoing, CalOptima may likely continue temporary telework alongside regular telework and working inside CalOptima buildings

- Although a date to return temporary teleworkers to the office has not yet been identified*, a cross-departmental workgroup has been formed to plan for the eventual transition of employees out of temporary telework

* Individual exceptions are evaluated by HR and accommodated as needed.

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COVID-19 Workgroup

- Preparing CalOptima to accommodate more employees in buildings by:
  - Implementing/Maintaining COVID-19 mitigating health and safety measures
  - Updating policies and procedures
    - Behavioral expectations (e.g., wearing face masks, social distancing, symptom checking, etc.)
    - Signage (e.g., traffic flow, etc.)
  - Communicating expectations to employees
- Monitoring and assessing the ever-changing guidance surrounding COVID-19

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Considering Telework Expansion

- Leadership is evaluating the effectiveness and benefits of the past six months of temporary telework in order to consider a recommendation to expand the regular telework program

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Intergovernmental Transfer Overview

Board of Directors Meeting
October 1, 2020

Candice Gomez, Executive Director, Program Implementation

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Intergovernmental Transfer (IGT)

- Background
- Funding Process and Partners
- CalOptima Total to Date
- Funded Projects
- COVID-19 Impact
- IGT 10 Status

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IGT Background

- CalOptima has participated in the Department of Health Care Services (DHCS) annual Rate Range IGT since 2010
- IGTs enable CalOptima and our governmental funding partners to receive additional revenue for services to Medi-Cal members
- IGT processes secure additional federal revenue to increase California's Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services to existing Medi-Cal members
  - IGTs 8–10: Funds must be used for Medi-Cal covered services included in CalOptima's DHCS contract for Medi-Cal members

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IGT Background (cont.)

- Contributions from eligible community funding partners can be matched through the IGT process up to upper rate range as established by the state's actuaries
- No guarantee of future availability of IGT funds
  - Best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries
- Board-approved spending plans are in place for IGTs 1–9

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IGT Funding Process

High-Level Steps:
1. CalOptima receives DHCS notice announcing IGT opportunity.
2. CalOptima secures funding partnership commitments.
3. CalOptima submits Letter of Interest to DHCS listing funding partners and their respective contribution amounts.
4. Funding partners wire their contribution amount and additional 20% fee to DHCS.
5. CMS provides matching funds to DHCS.
6. DHCS sends total amount to CalOptima.
7. From the total amount, CalOptima returns each funding partner's original contribution.
8. From the total amount, CalOptima also reimburses each funding partner's 20% fee and, where applicable, retained amount for Managed Care Organization tax (IGT 1–6 only).
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees.

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Current IGT Funding Partners

- Children and Families Commission of Orange County
- Orange County Health Care Agency
- Orange Fire Department
- Newport Beach Fire Department
- University of California, Irvine

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CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	$12.43 million	September 2012
IGT 2	$8.70 million	June 2013
IGT 3	$4.88 million	September 2014
IGT 4	$6.97 million	October 2015 (Classic) March 2016 (MCE)**
IGT 5	$14.42 million	December 2016
IGT 6	$15.24 million	September 2017
IGT 7	$15.91 million	May 2018
IGT 8	$42.76 million	April 2019
IGT 9	$43.96 million	April 2020
IGT 10*	TBD	TBD
Total Received	**$165.27 million**	

- Estimate; Pending DHCS Guidance ** Medi-Cal Expansion
- Determining unspent funds on closed projects is in progress

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IGT 1-7 Funded Projects

- Funds are available to provide enhanced benefits to existing Medi-Cal members
- Project examples include:
  - Internal initiatives such as Personal Care Coordinators, member and provider portal, depression screenings, etc.
  - Recuperative care and medical respite services
  - Expand safety net services to support clinics to become Federally Qualified Health Centers
  - Community grants
    - Outpatient mental health services for children, integrate mental health into primary care, medication assistance treatment services, dental services, social determinants of health and food distribution
- Unused funds from closed initiatives may be reallocated by the board to other qualifying enhanced services

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IGT 8-9 Funded Projects

- Funds must be used for CalOptima Medi-Cal covered services for our Medi-Cal members, with any expenditures not qualifying as medical expenses counted by the state as part of CalOptima's administrative expenses
- Project examples include:
  - Homeless Response Team
  - Hospital Data Exchange
  - Post Acute-Infection Prevention Quality Initiative

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IGT 5-7 COVID-19 Impacts

- Staff met with grantees to discuss impacts to their organization and grant deliverables
  - Heavily relying on virtual platforms, halt/decrease in routine care and increase in food and mental health services
  - On June 4, 2020 and September 3, 2020, the Board of Directors approved
    - Nine requests for no-cost extension
    - Three requests for budget line item revisions
    - Two requests for temporary modifications in scope of work

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IGT 10 Status

- On February 6, 2020, the Board of Directors approved CalOptima's pursuit of IGT 10 funding
  - Unlike prior IGTs, IGT 10 will cover an 18-month period
    - Rating period July 1, 2019–June 30, 2020 and July 1–December 31, 2020
    - Due to DHCS transition from fiscal to calendar year budget cycle
- Funder's contributions are estimated to be $78.6 million*
  - Funders must return final signed agreements to DHCS by September 2020
  - Two separate DHCS wire transfer requests anticipated between April–September 2021
- CalOptima's share is estimated to be $66 million*
  - CalOptima may receive funds after each rating period wire transfer

* Amounts may change based on actual enrollment and member mix.

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IGT 10 Next Steps

- Identify potential focus areas and initiatives
  - Consider member needs, opportunities to enhance Medi-Cal programs and supporting providers
  - Ensure alignment with 2020–2022 Strategic Plan identified priorities and objectives
- Engage stakeholders proposed allocation of IGT 10 funds
- Present final recommendations to the Board of Directors

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Board of Directors Meeting
October 1, 2020

CalOptima 2017–2019 Strategic Plan Closure and 2020–2022 Strategic Plan Update

This document provides an overview of CalOptima's work in the area of strategic planning. CalOptima routinely develops three-year strategic plans through an extensive process that engages the Board of Directors, executive team, staff and community stakeholders. At the end of 2019, we completed our 2017‑2019 Strategic Plan, and a document summarizing the initiatives follows this memo. We are currently in the middle of the first year of our 2020‑2022 plan. A brief summary of that plan is below, along with links to the plan's full text and an associated Environmental Scan document.

2017–2019 Strategic Plan Closure

CalOptima's 2017–2019 Strategic Plan focused on three priority areas: Innovation, Value, and Partnerships and Engagement; and two building blocks: Workforce Performance and Financial Strength. At the February 7, 2019, CalOptima Board of Directors (Board) meeting, staff presented an Information Item on the Year 2 Progress Report. Due to the completion of this three-year Strategic Plan at the end of the 2019, CalOptima is providing the attached Final Report, closing the remaining identified initiatives. A few highlights from the final year include:

- *Be Well OC:* CalOptima provided an $11.4 million prepayment for services to CalOptima members at the first wellness hub in Orange County. When completed, the wellness hub will be a single location that offers a seamless continuum of mental health care from triage to treatment. In addition, CalOptima staff are providing support to the Be Well collaborative by co-leading two workgroups: Close Treatment Gaps and Improve Access, and Establish Community Wellness Hubs. These are two of the six workgroups established by Be Well OC to address high-priority areas identified as needing the most attention and improvement.
- *Delivery System Study:* Presented to the Board in multiple sessions during 2019, the study brings together information and data about health care delivery throughout the health care industry and within CalOptima's delivery model. The study results are to inform future options for delivery system structure and practices by CalOptima, its health networks and providers.
- *Member Portal:* CalOptima launched its member portal in April 2019 and now provides online access to information in English, Spanish and Vietnamese.

2020–2022 Strategic Plan Update

Across several months in 2019, Chapman Consulting facilitated the development of CalOptima's 2020–2022 Strategic Plan. The process included:

- Reviewing the Strategic Plans from 2017–2019 and prior years

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- Conducting interviews with Board members and Executive staff
- Developing an Environmental Scan
- Facilitating meetings with key audiences
    - Full-day Board planning session
    - 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)
    - Meeting with health network representatives

The final 2020–2022 Strategic Plan builds on the achievements of the 2017–2019 Strategic Plan and identifies five Strategic Priorities:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

CalOptima's website includes postings of the 2020–2022 Strategic Plan approved at the December 5, 2019, Board meeting and the Environmental Scan.

Information about the Strategic Plan was shared with employees at all levels and is part of new employee orientation. The plan was also available to support the development of the Fiscal Year 2020–21 budget and the identification of new initiatives for employee goal setting. Staff is gathering information on the current and new initiatives that align with the five Strategic Priorities to enable ongoing monitoring and periodic updates to the Board.

The Strategic Plan was also shared in CalOptima's 2020 Report to the Community and presented during the January 2020 Community Alliance Forum, as well as meetings with the Orange County Health Improvement Partnership and the Coalition of Orange County Community Health Centers. These are the first steps to identifying synergies with other community organizations and developing support for CalOptima initiatives.

Next Steps

CalOptima is finalizing a workplan for implementing, monitoring and reporting progress on the 2020–2022 Strategic Plan. Progress reports on the 2020–2022 Strategic Plan will be provided to your Board on a semi-annual basis or as appropriate.

Attachments

1. 2017–2019 Strategic Plan Final Report
2. 2020–2022 Strategic Plan

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Strategic Plan 2017–2019

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Final Report

January 1, 2017–December 31, 2019

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Strategic Plan Final Report

The CalOptima Strategic Plan 2017–2019 Final Report encapsulates achievements across three years in the priority areas of innovation, value, and partnerships and engagement. Our endeavors to improve members' health care are always in partnership with Orange County's community of providers, advocates and stakeholders. We have you and others to thank for supporting this plan.

Innovation at CalOptima primarily means integration, and the integration efforts of the past three years are significant. We brought mental and physical health benefits together by directly administering mild to moderate mental health services and Applied Behavior Analysis in Medi-Cal. CalOptima transitioned California Children's Services to the Whole-Child Model, creating a seamless program for more than 12,000 medically complex children. And we prepared to launch the Health Homes Program to support the highest-risk members with enhanced care coordination.

Value is about quality of care delivered relative to the cost. For the duration of the Strategic Plan, CalOptima maintained our record of top quality in Medi-Cal as measured by the National Committee for Quality Assurance. At the same time, we upheld our commitment to keeping administrative costs low and setting appropriate provider payments via rate rebasing and other efforts.

Partnerships and Engagement strengthen all efforts on behalf of members, especially in the areas of homeless health and our Program of All-Inclusive Care for the Elderly (PACE). Community health centers were essential partners in developing new programs for members experiencing homelessness, such as Orange County's first-ever Clinical Field Teams. And collaboration with Community-Based Adult Services centers enabled CalOptima PACE to expand capacity and serve participants in a new way.

With this plan now complete, CalOptima has transitioned to the 2020–2022 Strategic Plan. And already we know that this next three-year period will be dynamic and challenging based on the realities of the COVID-19 pandemic. In this unprecedented time, our strategic priorities may change according to the environment, but our values won't. CalOptima will continue to put members first and work Better. Together. with our community. Thank you!



Richard Sanchez
Interim Chief Executive Officer

Board of Directors

Paul Yost, M.D. (Chair)
Anesthesiologist, CHOC Children's and St. Joseph Hospital

Dr. Nikan Khatibi (Vice Chair)
Anesthesiologist/Pain Medicine Specialist, Riverside Medical Clinic

Ria Berger
CEO, Healthy Smiles for Kids of Orange County

Ron DiLuigi
Retired Health Care Executive

Andrew Do
Supervisor, First District, Orange County Board of Supervisors

Alexander Nguyen, M.D.
Psychiatrist, Harbor-UCLA Medical Center

Lee Penrose
Health Care Executive

Clayton Chau, M.D., Ph.D.
Director, Orange County Health Care Agency

J. Scott Schoeffel
Health Care Attorney

Michelle Steel
Supervisor, Second District, Orange County Board of Supervisors

Doug Chaffee (Alternate)
Supervisor, Fourth District, Orange County Board of Supervisors

Note: Board members listed above oversaw the 2017–2019 Strategic Plan. A new Board was seated as of August 4, 2020.

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CalOptima Strategic Plan 2017–2019

Strategic Priorities

Innovation

Pursue innovative programs and services to optimize member access to care

1. **Delivery System Innovation**
   Use pay-for-performance programs, creative partnerships, sponsored initiatives and technology to empower networks and providers to drive innovation and improve member access.
2. **Program Integration**
   Implement programs that create an integrated service experience for members, including an integrated physical and behavioral health service model.
3. **Program Incubation**
   Incubate new programs or services that address unmet member needs in areas such as substance abuse, behavioral health services, childhood obesity and complex conditions.

Value

Maximize the value of care for members by ensuring quality in a cost-effective way

1. **Data Analytics Infrastructure**
   Establish robust information technology infrastructure and an integrated data warehouse to enable predictive modeling, performance accountability and data-based decision making.
2. **Pay for Value**
   Launch pay-for-performance programs and quality incentive initiatives that encourage provider participation, improve clinical quality and member experience outcomes, and spread best practices.
3. **Cost-Effectiveness**
   Implement efficient systems and processes to facilitate better understanding of internal cost drivers, eliminate administrative redundancies, and promote effective and standardized internal practices.

Partnerships and Engagement

Engage providers and community partners in improving the health status and experience of members

1. **Provider Collaboration**
   Enhance partnerships with networks, physicians and the Provider Advisory Committee to improve service to providers and members, expand access, and advance shared health priorities.
2. **Member Engagement**
   Seek input from the Member Advisory Committee and CalOptima's diverse membership to better understand member needs, and implement programs that strengthen member choice and experience.
3. **Community Partnerships**
   Establish new organizational partnerships and collaborations to understand, measure and address the social determinants of health that lead to health disparities among vulnerable populations.
4. **Shared Advocacy**
   Use provider and community relationships to educate stakeholders about health policy issues, and promote the value of CalOptima to members, providers and the broader population of Orange County.

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CalOptima Strategic Plan 2017–2019

Building Blocks

Workforce Performance

Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes

1. **Employer of Choice**
   Establish a feedback-rich culture to ensure accountability, optimize performance and retain high performers capable of advancing organizational objectives.
2. **Collaborative Culture**
   Drive collaboration to strengthen data-informed decision making, launch innovative member-centered programs and services, and evaluate shared performance.
3. **Operational Excellence**
   Review, measure and refine processes to ensure regulatory compliance, and pursue continuous improvement of programs and services for members.

Financial Strength

Provide effective financial management and planning to ensure long-term financial strength

1. **Strategic Goal Alignment**
   Ensure departmental budgets reinforce CalOptima's strategic priorities to advance the shared mission and values.
2. **Fiscal Management**
   Standardize the use of effective financial reporting and forecasting tools so directors develop sound departmental budgets, and promote a culture of transparency and accountability.

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Completed Projects

CalOptima Strategic Plan 2017–2019

January 1, 2017–December 31, 2019

✓ 2019	**Whole-Person Care (WPC) Pilot** **Strategic Plan Elements:** Innovation *Delivery System Innovation* *Program Integration* *Program Incubation*	Collaborated with DHCS, Orange County Health Care Agency and local stakeholders on the WPC Pilot. Participated in data exchange and provided personal care coordinators to better integrate care for members who are homeless and participating in WPC.
✓ 2019	**PACE Community-Based Primary Care Providers** **Strategic Plan Elements:** Innovation *Delivery System Innovation* Partnerships and Engagement *Provider Collaboration* *Community Partnerships*	Developed a community-based primary care provider option whereby more than 30 PACE participants were able to receive primary care services in their home or in a community location.
✓ 2019	**Homeless Health** **Strategic Plan Elements:** Innovation *Program Incubation* Partnerships and Engagement *Member Engagement* *Community Partnerships*	Committed a $100 million to strengthen services and resources for Orange County's homeless population. Approved approximately $43 million for specific investments in recuperative care, medical respite care, a regional wellness campus, Clinical Field Teams, CalOptima's Homeless Response Team, homeless coordination at hospitals and a Homeless Clinical Access Program. Developed four guiding principles to refine decision making, ensure investment in the most appropriate programs and respond to provider concerns.
✓ 2019	**Intergovernmental Transfers (IGTs)** **Strategic Plan Elements:** Innovation *Program Incubation* Financial Strength *Strategic Goal Alignment*	IGT 5: $11.4 million distributed for a regional wellness campus and $3.4 million in community grants. IGT 6/7: $10 million targeted for recuperative care and medical respite, and $20 million for community grants and internal projects. IGT 8: $43 million committed to Homeless Health Initiatives. IGT 9: Approximately $43 million allocated to support quality initiatives, such as expanded office hours, skilled nursing post-acute infection prevention, text messaging for members and other internal projects. IGT 10: Approximately $66 million in funding pending.

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CalOptima Strategic Plan 2017–2019

✓ 2019	**Proposition 56 Provider Payments** **Strategic Plan Elements:** Partnerships and Engagement *Provider Engagement*	Implemented enhanced funds distribution processes for improved internal and external efficiency.
✓ 2019	**Member Portal** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement*	Launched member portal with English, Spanish and Vietnamese access, providing members with mobile access to CalOptima information and services.
✓ 2019	**Electronic Provider Data Management** **Strategic Plan Elements:** Value *Data Analytics Infrastructure* *Cost-Effectiveness* Workforce Performance *Collaborative Culture* *Operational Excellence*	Finalized the scope of work to engage a vendor that will support the development and implementation of web-based provider data management processes for providers, health networks and CalOptima. Vendor procurement is in progress.
✓ 2019	**Health Homes Program (HHP)** **Strategic Plan Elements:** Innovation *Program Integration* Partnership and Engagement *Member Engagement* *Provider Collaboration*	Launched HHP on January 1, 2020, offering enhanced care management for members with chronic conditions and substance use disorders (as of January 1) and for members with serious mental illness (as of July 1).
✓ 2019	**Delivery System Study** **Strategic Plan Elements:** Innovation *Delivery System Innovation* Value *Cost-Effectiveness* Workforce Performance *Operational Excellence*	Completed the delivery system study and delivered the report to the CalOptima Board of Directors.

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Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2019	**CalOptima Technical Assistance Program** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration*	Enrolled more than 625 clinical professionals in this program, which supports achieving meaningful use of electronic medical records. The state extended program to September 30, 2020.
✓ 2019	**Be Well OC** **Strategic Plan Elements:** Innovation *Delivery System Innovation* *Program Incubation* Partnerships and Engagement *Community Partnerships*	Completed a $11.4 million prepayment for services at the first Be Well OC wellness hub in Orange. Continuing to co-lead the Closing Treatment Gaps and Establishing Community Wellness Hubs workgroups and participating as a member of the Substance Use Disorder Leadership Group.
✓ 2019	**Dental Care Integration** **Strategic Plan Elements:** Innovation *Program Incubation* Partnerships and Engagement *Provider Collaboration* *Community Partnerships*	Explored opportunities to carve in dental benefits to CalOptima Medi-Cal but concluded that it isn't possible at this time. The California Dental Association and Orange County Dental Society are reluctant to endorse an integration pilot until results from the first pilot by Health Plan of San Mateo are available, but that pilot has not begun. Further, DHCS had proposed dental integration as part of the next federal waiver, which is now delayed until 2022.
✓ 2019	**CalOptima Foundation** **Strategic Plan Elements:** Financial Strength *Fiscal Management*	Completed the dissolution of the foundation and transferred the remaining funds back to CalOptima.
✓ 2019	**Employee Engagement Study** **Strategic Plan Elements:** Workforce Performance *Employer of Choice* *Collaborative Culture*	Conducted a survey of employees to gain insight about the levels of engagement and workforce satisfaction. Created employee focus groups that made recommendations to executives about three areas needing improvement: employee voice, collaboration across departments and professional development. Some recommendations have been implemented and others will be addressed in the future.
✓ 2019	**Compensation Study** **Strategic Plan Elements:** Workforce Performance *Employer of Choice* Financial Strength *Fiscal Management*	Completed a compensation study and presented findings to the Board twice. The Board did not approve the recommended actions.

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CalOptima Strategic Plan 2017–2019

✓ 2019	**Temporary Staffing Vendor** **Strategic Plan Elements:** Workforce Performance *Operational Excellence* Financial Strength *Fiscal Management*	Contracted and onboarded new temporary services vendors.
✓ 2019	**CalOptima Website** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement* *Community Partnerships* Workforce Performance *Operational Excellence*	Redesigned www.caloptima.org to make it usable on mobile phones and more member-centric, as well as have a contemporary look and feel.
✓ 2019	**Technology Advancements** **Strategic Plan Elements:** Value *Data Analytics Infrastructure* Workforce Performance *Operational Excellence*	Migrated email to Office 365 in the Microsoft cloud and adopted secure cloud technology. Implemented Mediture, a new electronic health record for PACE.
✓ 2019	**Whole-Child Model** **Strategic Plan Elements:** Innovation *Program Integration* Partnerships and Engagement *Provider Collaboration* *Member Engagement* *Community Partnerships*	Prepared the financial and operational changes needed to transition to Whole-Child Model (WCM) from California Children's Services (CCS). Collaborated with the Department of Health Care Services (DHCS), Orange County Health Care Agency, health networks, members, providers and other local stakeholders to share information and ensure no disruption in members' care. WCM was implemented on July 1, 2019, and initial feedback has been positive from families and providers alike.
✓ 2019	**Substance Use Disorders** **Strategic Plan Elements:** Innovation *Delivery System Innovation* *Program Incubation* Partnerships and Engagement *Provider Collaboration* *Member Engagement*	Implemented interventions at the prescriber and member level to curb opioid misuse, exceeding our goal of achieving a 5% minimum decrease from first quarter 2018 to first quarter 2019.

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CalOptima Strategic Plan 2017–2019

✓ 2019	**PACE Alternative Care Setting Sites** **Strategic Plan Elements:** Innovation *Delivery System Innovation* Partnerships and Engagement *Provider Collaboration* *Community Partnerships*	Partnered with five Alternative Care Setting sites throughout Orange County, which now serve approximately 15% of CalOptima PACE participants.
✓ 2019	**PACE Letters of Support Process** **Strategic Plan Elements:** Innovation *Delivery System Innovation* Partnerships and Engagement *Provider Collaboration* *Community Partnerships*	Administered a process to accept and assess requests for letters of support from PACE organizations seeking to operate independently in Orange County. Board approved issuing two letters of support
✓ 2019	**Coding Improvements** **Strategic Plan Elements:** Value *Data Analytics Infrastructure* Workforce Performance *Operational Excellence* Financial Strength *Fiscal Management*	Engaged a vendor to transition the processing and analysis of Hierarchical Condition Category (HCC) and Risk Adjustment Factor (RAF) scores, with a goal of enhanced accuracy and increased reimbursement.
✓ 2019	**Directed Payments for Hospitals** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration* Financial Strength *Fiscal Management*	Collaborated with the local hospital association and provider community to implement a new directed payments process, including holding educational events to ensure their understanding of the requirements to obtain the supplemental funding.

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CalOptima Strategic Plan 2017–2019

✓ 2019	**OneCare Connect Marketing and Retention** **Strategic Plan Elements:** Innovation *Program Integration* Workforce Performance *Operational Excellence*	Developed 2019–20 plan to increase OneCare Connect membership through new sales and marketing initiatives, including member events.
✓ 2018	**NCQA Recognition** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration* *Member Engagement* *Community Partnerships* Workforce Performance *Operational Excellence*	Delivered quality health care and customer service, as assessed by the National Committee for Quality Assurance (NCQA), thereby maintaining CalOptima's top rating among California Medi-Cal plans for the fifth year in a row.
✓ 2018	**State Quality Award** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration* *Member Engagement* *Community Partnerships* Workforce Performance *Operational Excellence*	Recognized by DHCS for quality, earning the Outstanding Performance Award for a Large Scale Medi-Cal Plan for the fourth year in a row.
✓ 2018	**NCQA Accreditation** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration* Value *Cost-Effectiveness* Workforce Performance *Operational Excellence*	Achieved accreditation at the Commendable level after earning a near-perfect score on the accreditation renewal survey in August 2018.
✓ 2018	**Rate Rebasing** **Strategic Plan Elements:** Value *Cost-Effectiveness* Financial Strength *Fiscal Management*	Rebased capitated payment rates for CalOptima's delegated health networks to reflect recent costs and delivery model changes, resulting in an increase of approximately $14 million for health networks in 2019.

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CalOptima Strategic Plan 2017–2019

✓ 2018	**Medical Loss Ratio (MLR) Audit** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration* Financial Strength *Fiscal Management*	Completed the audit of contracted health networks' MLRs to ensure required rate of 85% or more in medical spending; requested corrective action plans from networks out of compliance.
✓ 2018	**PACE Service Area Expansion** **Strategic Plan Elements:** Innovation *Delivery System Innovation* Partnerships and Engagement *Provider Collaboration* *Community Partnerships*	Gained regulatory approval to serve all ZIP codes in Orange County, which enables CalOptima to reach seniors living in South Orange County.
✓ 2018	**Dual Eligible Special Needs Plan (D-SNP) Reauthorization** **Strategic Plan Element:** Partnerships and Engagement *Shared Advocacy*	Worked with members of Congress and in partnership with our associations to obtain permanent reauthorization of D-SNP plans, including CalOptima's OneCare.
✓ 2018	**Children's Health Insurance Program (CHIP) Reauthorization** **Strategic Plan Elements:** Partnerships and Engagement *Community Partnerships* *Shared Advocacy*	Worked with federal advocates and trade associations to gain a 10-year reauthorization of CHIP funding, through 2027.
✓ 2018	**Member Health Needs Assessment** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement* *Community Partnerships* Innovation *Program Incubation*	Finalized the data and compiled a 70-page report summarizing five key findings in these areas: social determinants of health, mental health, primary care, provider access and dental care.

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CalOptima Strategic Plan 2017–2019

✓ 2018	**Regulatory Audits** **Strategic Plan Elements:** Value *Cost-Effectiveness* Workforce Performance *Operational Excellence*	Maintained a culture of compliance to ensure CalOptima and delegated entities were continuously audit-ready. DHCS and the Centers for Medicare & Medicaid Services conducted nine regulatory audits of CalOptima's programs in 2018. The annual Medi-Cal audit resulted in our best performance ever, with only one finding.
✓ 2018	**Child Health and Disability Prevention (CHDP)** **Strategic Plan Elements:** Innovation *Program Integration* Workforce Performance *Operational Excellence*	Improved the claims process for providers delivering CHDP services by transitioning responsibility for CHDP services from CalOptima to the health networks.
✓ 2018	**Medi-Cal Provider Enrollment** **Strategic Plan Element:** Partnerships and Engagement *Provider Collaboration*	Led efforts to ensure providers were enrolled in Medi-Cal by January 1, 2019, in compliance with new regulations. Through outreach, 139 primary care providers became enrolled or started the process, thereby eliminating the need for members to change providers.
✓ 2018	**Whole-Child Model (WCM) Provider Network** **Strategic Plan Element:** Partnerships and Engagement *Provider Collaboration*	Built a network of California Children's Services-paneled providers that complied with revised state requirements on network adequacy. Collaborated with health networks and contracted with independent providers to ensure the network was in place for a filing deadline of January 2, 2019.
✓ 2018	**WCM Family Advisory Committee** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement* *Community Engagement*	Appointed the founding members of our newest advisory committee, which will guide our effective implementation of WCM.

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Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2018	**Applied Behavior Analysis (ABA) for Non-Autism Diagnoses** **Strategic Plan Elements:** Innovation *Program Integration* Partnerships and Engagement *Member Engagement*	Prepared for another transition of behavioral health services, integrating ABA services for children with non-Autism Spectrum Disorders, effective July 1, 2018.
✓ 2018	**Childhood Obesity Program** **Strategic Plan Elements:** Innovation *Program Incubation* Value *Cost-Effectiveness* Partnerships and Engagement *Member Engagement*	Redesigned and implemented Shape Your Life, a comprehensive program to address childhood obesity.
✓ 2018	**Perinatal Care** **Strategic Plan Elements:** Innovation *Program Incubation* Value *Pay for Value* Partnerships and Engagement *Provider Collaboration* *Member Engagement*	Launched Bright Steps to provide quality prenatal and postpartum services to members through a program that reflects best practices and includes provider incentives.
✓ 2018	**Quality Care Campaign** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement* Workforce Performance *Employer of Choice*	Created and implemented a multifaceted marketing campaign to raise awareness of preventive care at all ages, from infancy to the golden years.

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Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2018	**Timekeeping Enhancements** **Strategic Plan Elements:** Workforce Performance *Employer of Choice* *Operational Excellence*	Implemented a timekeeping system for all nonexempt employees using timeclocks to ensure staff accountability and efficiency across the agency.
✓ 2018	**457(b) Vendor Change** **Strategic Plan Element:** Workforce Performance *Employer of Choice*	Improved overall employee experience with CalOptima's 457(b) plan by changing to a vendor with enhanced plan administration, a simplified investment selection, and improved tools and education.
✓ 2018	**Crucial Conversations Course** **Strategic Plan Element:** Workforce Performance *Collaborative Culture*	Engaged leaders and staff in a high-priority, skill-based training class, conducted by a CalOptima facilitator who will offer the course on an ongoing basis.
✓ 2017	**Behavioral Health Integration** **Strategic Plan Elements:** Innovation *Delivery System Innovation* *Program Integration* Value *Cost-Effectiveness* Partnerships and Engagement *Provider Collaboration*	Quickly developed and capably implemented all the necessary infrastructure to manage the provision of Medi-Cal behavioral health services for mild to moderate conditions and ABA services using a network of CalOptima-contracted providers, with a go-live date of December 29, 2017.
✓ 2017	**Non-Medical Transportation** **Strategic Plan Element:** Innovation *Program Integration*	Implemented the benefit to provide non-medical transportation for adults traveling to Medi-Cal services covered by CalOptima and services carved out, thereby removing barriers to accessing all types of care.
✓ 2017	**Palliative Care** **Strategic Plan Elements:** Innovation *Program Integration* Value *Cost-Effectiveness*	Adopted appropriate policies and procedures to ensure the delivery of palliative care services through Medi-Cal, with the goal of providing access to cost-effective and compassionate care to members with chronic illnesses or members at the end of life.

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Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2017	**OneCare Connect Program Reauthorization** **Strategic Plan Elements:** Innovation *Program Integration* Partnerships and Engagement *Shared Advocacy*	Successfully advocated for DHCS and the Legislature to reauthorize the Cal MediConnect program, including CalOptima's OneCare Connect program, through 2019. SB 97 passed the Legislature and was signed by the governor on July 10, 2017.
✓ 2017	**OneCare Connect Enrollment** **Strategic Plan Element:** Partnerships and Engagement *Member Engagement*	Changed enrollment policies in OneCare Connect to help minimize disruption of services to members while their eligibility status is being updated.
✓ 2017	**Nurse Practitioners at PACE** **Strategic Plan Element:** Innovation *Delivery System Innovation*	Successfully advocated for federal approval for CalOptima PACE nurse practitioners to perform routine primary care services, resulting in reduced costs while maintaining high-quality care.
✓ 2017	**Mega Reg Implementation: GARS** **Strategic Plan Element:** Innovation *Program Integration*	Completed a timely and effective implementation of the first stage of Mega Reg-related changes, specifically an updated Grievance and Appeals Resolution Services (GARS) process for Medi-Cal members. The Mega Reg modernized Medicaid managed care regulations to improve members' experience.
✓ 2017	**New Federal Advocate** **Strategic Plan Element:** Partnerships and Engagement *Shared Advocacy*	Transitioned to a new federal advocate, Akin Gump, a top-tier Washington, D.C.-based firm with extensive health care experience, ensuring important guidance remains available considering the changing landscape of federal health care reform.
✓ 2017	**FY 2017 Financial Audit** **Strategic Plan Element:** Financial Strength *Fiscal Management*	Completed CalOptima's annual financial audit, with positive results in that the auditor found no material misstatements and made no changes.

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Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2017	**2017 Pay for Value Program** **Strategic Plan Element:** Value *Pay for Value*	Created a payment incentive to reward providers who show improvement in high-impact areas, such as preventive care and hospital readmission.
✓ 2017	**Member and Provider Incentives** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement* *Provider Collaboration*	Adopted new quality initiatives to improve members' health outcomes, specifically in postpartum care, cervical cancer screenings and breast cancer screenings.
✓ 2017	**Good Health Campaign** **Strategic Plan Element:** Partnerships and Engagement *Member Engagement*	Launched a major health education campaign in 2017 to promote preventive health screenings and better wellness practices. The campaign aimed to improve members' health behaviors and health outcomes.
✓ 2017	**Community Events Policies Update** **Strategic Plan Element:** Partnerships and Engagement *Community Partnerships*	Improved CalOptima's community events policies so community partners can more easily request support and staff can respond based on new Board-approved financial thresholds.
✓ 2017	**CCSC Location** **Strategic Plan Element:** Partnerships and Engagement *Community Partnerships*	Successfully extended CalOptima's agreement with the Orange County Social Services Agency to continue providing community resources and information at the County Community Service Center (CCSC).
✓ 2017	**Information Technology: CORE Standards** **Strategic Plan Element:** Value *Data Analytics Infrastructure*	Improved the speed and efficiency of claims processing by implementing Committee on Operating Rules for Information Exchange (CORE) Standards. Providers will now have quicker, more cost-effective access to member claims data.
✓ 2017	**Tableau Implementation** **Strategic Plan Elements:** Value *Data Analytics Infrastructure* *Pay for Value*	Procured a new business intelligence and data analytics platform to promote departmental self-service analytics and data-based decision making.

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Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2017	**Information Security** **Strategic Plan Element:** Workforce Performance *Operational Excellence*	Improved the protection of members' sensitive personal and health information through our information technology security workforce, preventing critical threats to CalOptima's systems.
✓ 2017	**Workforce Development** **Strategic Plan Elements:** Workforce Performance *Employer of Choice* *Collaborative Culture*	Offered a complete array of employee engagement opportunities, including quarterly All Hands meetings, health and wellness events, Employee Activities Committee activities, member scholarship contest, and performance reviews/feedback. Launched the new Leadership Development Series to improve leaders' skills via education provided by outside experts.

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STRATEGIC PLAN 2020–2022



CalOptima
A Public Agency
Better. Together.

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A Message From the 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

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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

Programs

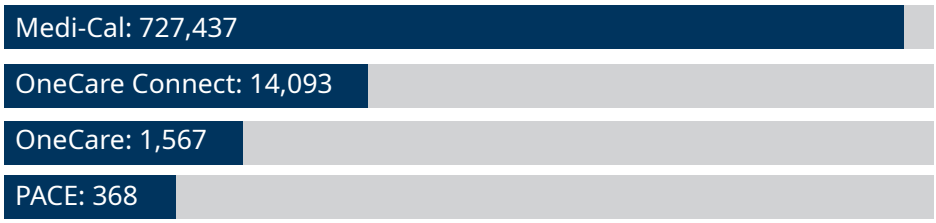
Medi-Cal (California's Medicaid Program): For low-income children, adults, seniors and persons with disabilities.

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. 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 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. PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal.

As of October 31, 2019, CalOptima has approximately 743,000 members:



Health Insurance Coverage in Orange County

CalOptima covers more than 20% of Orange County residents.

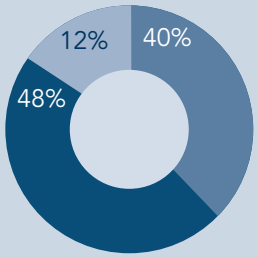
Current Health Insurance Coverage Type	Orange County
Uninsured	6.7%
Medicare and Medicaid (Dual Eligibles)	3.0%
Medicare	11.2%
Medicaid	19.1%
Employment-Based	51.8%
Privately Purchased	7.5%
Other Public Coverage	0.7%

Source: California Health Interview Survey, 2017



CalOptima Profile

Members by Age



Age 0–18	40%
Age 19–64	48%
Age 65+	12%

As of October 31, 2019

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 quality health care services in a cost-effective, compassionate manner.

96¢ of every **$1**

Provider Network Composition

CalOptima has a strong provider network to serve our members. As of October 31, 2019, this includes:

- 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 alternative 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 past three years, and this is expected to continue for the foreseeable future. The Centers for Medicare & 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 Gavin Newsom. 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 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 and CMC transitions.

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Health Care Landscape Review (continued)

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 multifaceted approach is necessary to respond to the needs of County residents experiencing homelessness. CalOptima has committed enhanced funding for 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 in the field and increased preventive and primary care at shelters, establishing an internal homeless response team, and 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 prepaying 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.







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Strategic Plan Development Process

To develop our 2020–2022 Strategic Plan, we gathered input from a wide range of CalOptima stakeholders:

Step 1

CalOptima's Board members, executive team and advisory committee leaders were interviewed to gather feedback about the 2017–2019 Strategic Plan as well as the issues and challenges facing the health plan over the next three years.

Step 2

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.

Step 3

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.

Step 4

The draft 2020–2022 Strategic Plan was presented to the Board on November 7, 2019, for review and discussion.

Step 5

The final 2020–2022 Strategic Plan was adopted by the Board on December 5, 2019.

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Strategic Priorities and Objectives

Our members are the essential focus of the Strategic Priorities and Objectives for the 2020–2022 Strategic Plan and are supported by the programs and services provided by CalOptima.



Innovate and 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 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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Board of Directors

Paul Yost, M.D. (Chair)
Anesthesiologist, CHOC Children's and St. Joseph Hospital
Designed seat: Licensed physician, representing a health network

Dr. Nikan Khatibi (Vice Chair)
Anesthesiologist, Pain Specialist and Addiction Medicine Physician
Designated seat: Licensed medical professional, not representing a health network

Ria Berger
CEO, Healthy Smiles for Kids of Orange County
Designated seat: Community clinic representative

Doug Chaffee
Orange County Board of Supervisors Supervisor, Fourth District
Designated seat: Orange County Board of Supervisors (alternate)

Ron DiLuigi
Retired Health Care Executive
Designated seat: Legal resident of Orange County

Andrew Do
Orange County Board of Supervisors Supervisor, First District
Designated seat: Orange County Board of Supervisors

Alexander Nguyen, M.D., MPH
Psychiatrist, Long Beach Veterans Affairs Medical Center
Designated seat: Family member of a CalOptima member

Lee Penrose
Health Care Executive
Designated seat: Current or former hospital administrator

Richard Sanchez, REHS, MPH
Director, Orange County Health Care Agency
Designated seat (non-voting): Orange County Health Care Agency

J. Scott Schoeffel
Attorney
Designated seat: Legal or finance professional

Michelle Steel
Orange County Board of Supervisors Supervisor, Second District
Designated seat: Orange County Board of Supervisors

CalOptima
A Public Agency
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505 City Parkway West, Orange, CA 92868
www.caloptima.org

The 2020–2022 Strategic Plan was created with the assistance of Athena Chapman and Caroline Davis from Champan Consulting. This plan was adopted by the CalOptima Board of Directors on December 5, 2019, and provides a framework for future direction. This document does not authorize expenditure of funds or commitment of resources.

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A Public Agency

CalOptima

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2020 Department of Health Care Services Medical Audit

Board of Directors Meeting
October 1, 2020

TC Roady, Director, Regulatory Affairs & Compliance

Back to Agenda

Background

- Three Scopes
  - Non-Seniors and Persons with Disabilities (Non-SPD) Medi-Cal members (*annual*)
  - SPD Medi-Cal members (*tri-annual*)
  - Medicaid-based services in Cal MediConnect (*tri-annual*)
- Delegate Involvement (Monarch)
- Review Areas
  - Utilization Management
  - Case Management & Coordination of Care
  - Availability and Accessibility
  - Member's Rights
  - Quality Management
  - Administrative and Organizational Capacity



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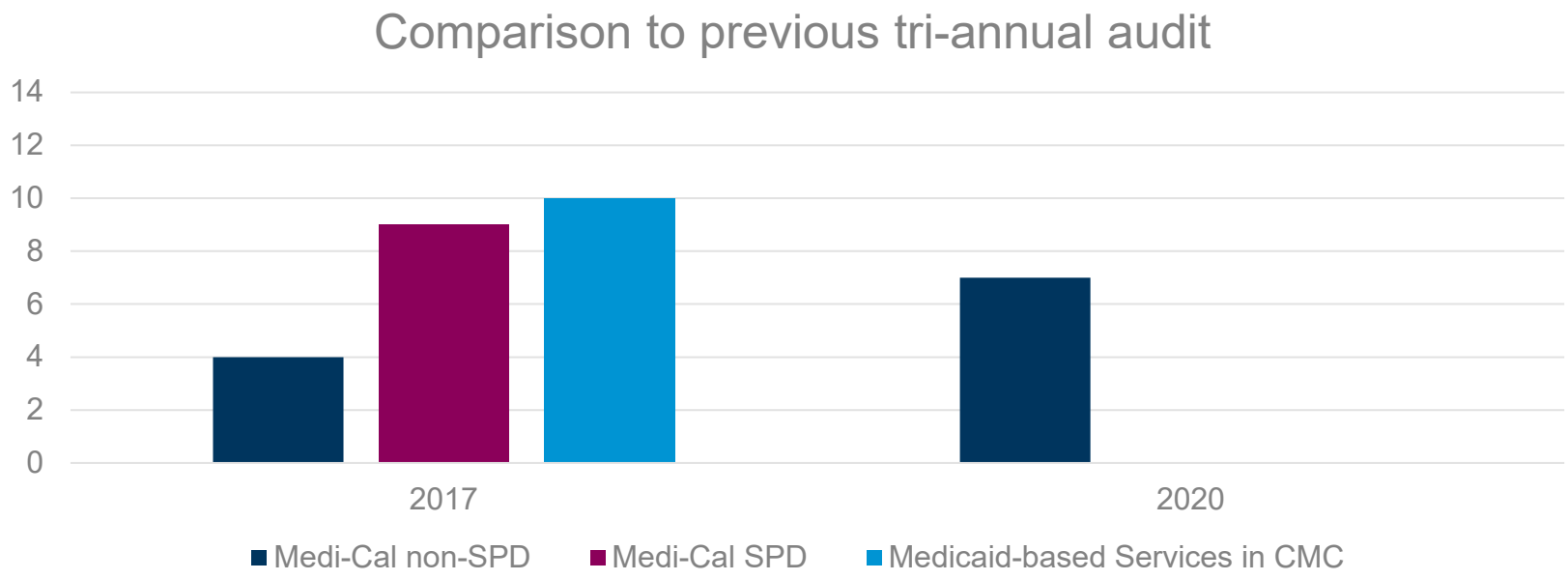
Findings

- Seven findings
  - 7 in Medi-Cal non-SPD
  - 0 in Medi-Cal SPD
  - 0 in Medicaid-based services in Cal MediConnect (CMC)



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CalOptima
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Findings and Remediation

- Access and Availability of Care (3 findings)
  - Finding: The Plan did not communicate and enforce providers' compliance with the timeliness standards because the survey report outcome did not identify and analyze the performance of non-compliant individual providers.
    - Remediation: CalOptima will distribute a detailed report to Health Networks that identifies individual non-compliant providers. CalOptima will notify individual providers of non-compliance. Health Networks will be held accountable via a Quality Improvement Plan (QIP). Provider-specific longitudinal monitoring coupled with an escalation process will ensure the enforcement and compliance of regulatory requirements.
  - Finding: The Plan did not effectively monitor wait times for member calls to providers' offices (speed to answer and return calls).
    - Remediation: CalOptima will revise its vendor's scope of work to include the tracking and monitoring of call answering and call return utilizing a mystery shopper call methodology.
  - Finding: The Plan did not communicate, enforce, and effectively monitor providers' compliance with in-office wait times. The Plan was not able to identify individual non-compliant providers.
    - Remediation: CalOptima will leverage calls made to Customer Service to conduct a focused study. Members with a recent office visit will be queried on office wait times. Data will be monitored on a quarterly basis and provider follow-up will occur as necessary. Provider-specific longitudinal monitoring coupled with an escalation process will ensure the enforcement and compliance of regulatory requirements.

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Findings and Remediation (cont.)

- Grievance System (4 findings)
  - Finding: The Plan does not have a policy and procedure (P&P) to distinguish a grievance from an inquiry.
    - Remediation: CalOptima revised an existing P&P to distinguish a grievance from an inquiry. Staff training will follow.
  - Finding: The Plan did not correctly identify and process quality of care (QOC) grievances.
    - Remediation: CalOptima revised its process to ensure appropriate identification and processing of QOC grievances. The process will be tested in October, fully implemented in November, and monitored thereafter to ensure corrective action is successful and sustained.
  - Finding: The Plan did not immediately submit all the QOC grievances to its medical director for action.
    - Remediation: CalOptima created a new process workflow to ensure clear and collaborative handoffs between impacted departments, which will ensure a Medical Director has timely access to Provider responses and medical records, when available. The process will be tested in September and October, fully implemented in November, and monitored thereafter to ensure corrective action is successful and sustained.
  - Finding: The Plan sent resolution letters to members without completing the investigation process to resolve both quality of service and quality of care grievances.
    - Remediation: The process was revised to ensure that the Medical Director has an opportunity to review relevant information (Provider response to grievance and medical records, when available) promptly and therefore make decisions and recommendations that can be incorporated into the Resolution Letter within timeframes. The process will be tested in October, fully implemented in November, and monitored thereafter to ensure corrective action is successful and sustained.

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CalOptima
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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

September 3, 2020

A Regular Meeting of the CalOptima Board of Directors was held on September 3, 2020, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Interim Chief Executive Officer, Richard Sanchez called the meeting to order at 2:00 p.m. and Supervisor Andrew Do led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: None

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

Mr. Sanchez announced that he would like to reorder the agenda to hear Report Item 3., Consider Election of Officers of the CalOptima Board of Directors, to ensure an orderly and efficient meeting.

REPORTS

3. Consider Election of Officers of the CalOptima Board of Directors

Mr. Sanchez introduced the item and asked if there were any recommendations for Board Chair and Board Vice Chair.

Director Schoeffel recommended that Supervisor Do serve as the Chair of the CalOptima Board of Directors.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors elected Supervisor Andrew Do to serve as Board Chair through December 31, 2020, or until such time as a successor is elected, unless he shall sooner resign or be removed from office. (Motion carried 9-0-0)***

Director Schoeffel also recommended that Isabel Becerra serve as Vice Chair of the CalOptima Board of Directors.

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Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors elected Isabel Becerra to serve as Board Vice Chair through December 31, 2020, or until such time as a successor is elected, unless she shall sooner resign or be removed from office. (Motion carried 9-0-0)***

Chair Do and Vice Chair Becerra thanked their colleagues for their support.
Chair Do noted that he would like to ensure that the CalOptima Board and its committees are inclusive of all community stakeholders and that steps would be taken to better ensure that stakeholders could provide input on how CalOptima can make health care services available and accessible to the members we serve, especially in light of COVID-19.

Chair Do also thanked Interim Chief Executive Officer Richard Sanchez for his work during the last five months, in taking the helm and leading during a tumultuous time.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Mr. Sanchez briefly highlighted several items from his report, including the recent notification from the Department of Health Care Services (DHCS) of its intent to reduce the Medi-Cal Expansion (MCE) rates it pays CalOptima. He also noted that staff is awaiting details from the state and will keep the Board and our stakeholders updated as information is received. In addition, Mr. Sanchez updated the Board on the upcoming Medi-Cal Pharmacy Carve-out and COVID-19.

PUBLIC COMMENTS

1. Kerri Ruppert Schiller, CHOC – Oral re: Agenda Item 8., Consider Authorizing Actions Related to Payments to and Contract Terms with the Children's Hospital of Orange County Physician-Hospital Consortium Health Network

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the August 6, 2020 Regular Meeting of the CalOptima Board of Directors
b. Receive and File Minutes of the June 11, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee and the June 11, 2020 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

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

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REPORTS

4. Consider Authorizing Contract(s)/Contract Amendment(s) with Vendor(s) and Authorizing Unbudgeted Funds to Provide Communication Devices, and Ongoing Service Plans and Related Services to Participants in the CalOptima Program of All-Inclusive Care for the Elderly
Elizabeth Lee, Director of CalOptima's Program of All-Inclusive Care for the Elderly (PACE), introduced the item.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors 1). Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to: a.) Amend CalOptima's existing contract with Critical Signal Technology, Inc. to include virtual care equipment (smartphones) to be provided along with ongoing voice and data service plans for CalOptima Program of All-Inclusive Care for the Elderly (PACE) participants; and b.) Extend the existing telehealth application contract with VSee Lab, Inc. (VSee) through June 30, 2021; 2.) Authorized unbudgeted expenditures in an amount up to $132,000 from existing reserves to support this initiative through June 30, 2021; and 3.) Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose. (Motion carried 9-0-0)***

5. Consider Adoption of Resolution Approving and Adopting Updated Human Resources Policies
Brigette Gibb, Executive Director, Human Resources, introduced the item.

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors Adopted a Resolution approving CalOptima's updated human resources policies: 1.) GA.8037 Leave of Absence; 2.) GA.8052 Drug-Free & Alcohol-Free Workplace; and 3.) GA.8058 Salary Schedule. (Motion carried 9-0-0)***

6. Consider Approval of Proposed Revisions to CalOptima's Customer Service Policies and Procedures
Belinda Abeyta, Executive Director, Operations, introduced the item.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors Approved modification of the following Operations policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows: 1.) AA.1220: Member Billing; and 2.) DD.2006: Enrollment In/ Eligibility with CalOptima. (Motion carried 9-0-0)***

7. Consider Approving Modifications to CalOptima's Medi-Cal and OneCare Connect Policy GG.1822: Process for Transitioning CalOptima Members Between Levels of Care
Emily Fonda, M.D., Deputy Chief Medical Officer, introduced the item.

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Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors Approved modifications to CalOptima's Medi-Cal and OneCare Connect Policy GG.1822: Process for Transitioning CalOptima Members Between Levels of Care pursuant to CalOptima's regular review process and consistent with regulatory requirements. (Motion carried 9-0-0)***

8. Consider Authorizing Actions Related to Payments to and Contract Terms with the Children's Hospital of Orange County Physician-Hospital Consortium Health Network

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

Michelle Laughlin, Executive Director, Provider Network Operations, introduced the item.

Chair Do asked Mr. Sanchez to address the public comment from CHOC, specifically that CHOC was not in agreement with all aspects of CalOptima's rebasing methodology. Mr. Sanchez clarified that CalOptima uses a third-party actuary to assist with the rebasing effort. Nancy Huang, Chief Financial Officer, added that CalOptima has been using essentially the same methodology for rebasing for over two decades. Ms. Huang also explained that the results are based on encounter data and that, based on extensive review of the data and numerous meetings between CHOC and CalOptima staff, CHOC did not identify any errors in the data or methodology.

Chair Do thanked staff for the additional information and noted that the CalOptima Board is considering this item as an accommodation to CHOC.

Director Corwin and Vice Chair Becerra raised concerns about whether CHOC's rates were going to include supplemental payments in the next fiscal year. Ms. Huang responded that base rates will be at the level prescribed by the rebasing effort just completed. She added that no new supplemental payments are planned for CHOC.

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors: 1.) Authorized monthly transitional supplemental payments to Children's Hospital of Orange County (CHOC) in an amount of up to $160,000 for the months of September 2020 through June 2021, for a total amount not to exceed $1.6 million; 2.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment to the CHOC Physician-Hospital Consortium hospital contract reflecting these monthly supplemental transition payments; and 3.) Made a finding that the transitional supplemental payments are for a public purpose and in furtherance of CalOptima's mission and statutory purpose. (Motion carried 8-0-0; Director Schoeffel absent)***

9. Consider Authorizing Renewal of the Program of All-Inclusive Care for the Elderly Primary Care Provider (PCP) Incentive Program and Related Changes to PCP Contracts

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

during the discussion and vote.

Miles Masatsugu, M.D., Medical Director, PACE, introduced the item.

Following a number of Board member questions, Mr. Sanchez offered to return to a future meeting with an Information Item to provide Board members with additional information on the PACE Program.

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors, Specific to CalOptima's Program of All-Inclusive Care for the Elderly (PACE), authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to: 1.) Renew the CalOptima PACE PCP Incentive Program, subject to applicable regulatory approvals; 2.) Amended CalOptima's current PACE PCP contracts to renew the PACE PCP Incentive Program; and 3.) Included the PACE PCP Incentive Program language in all future PACE PCP contracts, including those of community-based physicians serving CalOptima PACE members. (Motion carried 8-0-0; Director Schoeffel absent)***

10. Consider Actions Related to Intergovernmental Transfer (IGT) 5 Community Grant Contract(s) in Response to COVID-19

Vice Chair Becerra did not participate in this item based on her affiliation with the Coalition of Orange County Community Health Centers and left the room during the discussion and vote.

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

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors, Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contract with IGT 5 community grantee Korean Community Services, Inc. (KCS) to allow for a no-cost time extension to the grant through no later than October 31, 2021 for the purpose of allowing KCS more time for completing workplan deliverables. (Motion carried 8-0-0; Vice Chair Becerra absent)***

11. Consider Appointments of Member Advisory Committee and Provider Advisory Committee Chair and Vice Chair

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors, Appointed Christine Tolbert as the MAC Chair and Pamela Pimentel as the MAC Vice Chair, each for a two-year term ending June 30, 2022; and Appointment of Junie Lazo-Pearson, Ph.D. as the PAC Chair and John Nishimoto as PAC Vice Chair, each for a two-year term ending June 30, 2022. (Motion carried 9-0-0)***

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12. Consider Recommended Appointment to the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors Appointed the following individual to serve a two-year term on the Member Advisory Committee, effective September 3, 2020: Kate Polezhaev to serve as the Consumer Representative for a term ending June 30, 2022. (Motion carried 9-0-0)***

13. Consider Authorizing Expenditures in Support of CalOptima's Participation in a Community Event

Supervisor Steel asked that staff return with details on the expenditures by organization for all events CalOptima sponsors.

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors, 1.) Authorized expenditures for CalOptima's participation in the following community events: a.) Up to $10,000 of CalOptima-branded promotional items for Santa Ana Unified School District (SAUSD) free COVID-19 Testing Events and school activities on or before June 2021; and b.) Up to $10,000 at the Vietnamese Community of Southern California's Virtual 2020 Mid-Autumn Festival on Thursday, October 1, 2020; 2.) Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3.) Authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 9-0-0)***

ADVISORY COMMITTEE UPDATES

14. Member Advisory Committee Update

Christine Tolbert, Member Advisory Committee (MAC) Chair, provided an update on recent MAC activities, and invited members of the Board to attend a future MAC meeting.

15. Provider Advisory Committee Update

John Nishimoto, Provider Advisory Committee (PAC) Chair, provided an update on recent PAC activities and thanked the Board for the opportunity to serve on the PAC Chair for the past two years. Dr. Nishimoto also invited members of the Board to attend a future PAC meeting or the upcoming Joint Advisory Committee meeting on October 8, 2020, which includes the MAC, PAC, and the OneCare Connect Member Advisory Committee (OCC MAC) and the Whole-Child Model Family Advisory Committee (WCM FAC).

Chair Do announced he was reordering the agenda to consider CS.1, Closed Session before hearing the Information Items.

CLOSED SESSION

The Board of Directors adjourned to closed session at 3:35 p.m. pursuant to Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer).

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The Board reconvened to open session at 5:24 p.m. and Chair Do reported out that the Board met in closed session to discuss the performance of the Interim Chief Executive Officer. The Board directed staff to agendize for the October meeting an appointment of a Chief Executive Officer. In the meantime, the Chair would appoint an ad hoc comprised of the Chair and Vice Chair to negotiate terms of that employment agreement and bring back to the Board for consideration.

INFORMATION ITEMS
The following agenda items were continued to the October Board meeting.

16. COVID-19 Update
17. Medi-Cal Pharmacy Carve Out
18. Intergovernmental Transfer Overview
19. Strategic Plan Update
20. Chief Executive Officer Recruitment Update
21. July 2020 Financial Summary
22. Compliance Report
23. Federal and State Legislative Advocates Reports
24. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS
Board Members thanked one another for contributing to a collaborative and productive meeting.

ADJOURNMENT
Hearing no further business, Chair Do adjourned the meeting at 5:30 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: October 1, 2020

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 20, 2020

A Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on May 20, 2020 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:08 p.m. and led the Pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair (in-person); Dr. Nikan Khatibi (via teleconference)

Members Absent: Alexander Nguyen M.D.

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

PUBLIC COMMENTS
There were no public comments.

CONSENT CALENDAR

1. Approve the Minutes of the February 19, 2020 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Chair Yost, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 2-0-0; Director Nguyen absent)***

REPORTS

2. Consider Recommending Board of Directors' Approval of the 2019 CalOptima Utilization Management (UM) Program Evaluation and the 2020 CalOptima UM Program.
Tracy Hitzeman, R.N., Executive Director, Clinical Operations, reviewed the 2019 UM Program Evaluation, which measures plan performance against the 2019-approved goals. Notable accomplishments included the successful transition of CalOptima members eligible with the

California Children's Services Program (CCS) to the Whole Child Model (WCM) Program on July 1, 2019, and improved timeliness of CalOptima Direct (COD) expedited requests processing, exceeding goal of 98% and maintaining routine request processing with an average of 99.95% within turn-around-times. Areas of opportunity that staff identified in the 2019 UM Program Evaluation included improving visibility of operational performance of direct and delegated health networks and strengthening monitoring and auditing functions through inter-rater education and identification of best practices. Ms. Hitzeman noted that the results and outcomes from the 2019 Evaluation help inform areas of opportunity to include in the 2020 UM Program. Ms. Hitzeman presented an overview of the program description, including revisions and additions included in the proposed UM Program for 2020. The proposed changes are necessary to meet the requirements specified by the Centers of Medicare & Medicaid Services, California Department of Health Care Services, and the National Committee on Quality Assurance (NCQA) accreditation standards.

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors approval of the 2019 CalOptima Utilization Management Program Evaluation and the 2020 CalOptima UM Program. (Motion carried 2-0-0; Director Nguyen absent)***

INFORMATION ITEMS

3. COVID-19 Impact on Quality and Population Health Management

Kelly Rex-Kimmet, Director, Quality Analytics, provided an update on the impact that COVID-19 has had on quality reporting requirements. Due to the impact of COVID-19 on provider offices, the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) have issued guidance related to quality reporting requirement for measurement year (MY) 2019. Ms. Rex-Kimmet noted that with the requirement for Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results to be reported to CMS for MY 2019 performance suspended, this will impact the OneCare program star rating. Since no new data will be available, we will be rated based on CalOptima MY 2018 performance.

Esther Okajima, Director, Quality Improvement, provided a brief overview on COVID-19 and its Impact on Member Experience and Provider Experience. Ms. Okajima reviewed some of the main issues that CalOptima members are reporting which include delays in getting care, lack of testing availability, appointments getting rescheduled or cancelled, and denied testing or providers not making referrals to test members. Members are also reporting delays in obtaining medications and durable medical equipment (DME). For CalOptima providers, their reported experiences include: the need to change hours, consolidating services and sites, canceling elective surgeries and procedures, changing to phone consultations/telehealth, lack of clarity on testing sites and testing strategy. CalOptima also received several inquiries regarding Community-Based Adult Services (CBAS) hours of operation. With regard to testing, Miles Masatsugu, M.D., Medical Director, added that CalOptima has been working closely with the County to ensure that members are able to get tests if they are symptomatic. Dr. Masatsugu also noted that because the guidance is continuing to be updated frequently,CalOptima follows the guidelines communicated by the County Health Officer and Orange County Health Care Agency for COVID-19 testing criteria.

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Related to CBAS, Chair Yost mentioned that he had received a letter about possible cuts to the program. Interim CEO, Richard Sanchez responded that this is part of the Governor's May Revise of the state budget and CalOptima has received requests from CBAS providers regarding a letter of support. Chair Yost responded that the QAC Committee would be supportive of the CalOptima Board sending a letter of support for the CBAS program.

Pshyra Jones, Director, Population Health Management, reported on member outreach efforts to emerging risk populations during the pandemic. Ms. Jones noted that CalOptima is providing COVID-19 outreach and prevention awareness via weekly mailings and has modified guidance for expectant mothers and best practices during delivery. In addition, CalOptima is providing general education and prevention awareness via an interactive voice response campaign. CalOptima has created a COVID-19 Community Awareness campaign and there are also educational videos on the CalOptima website.

Edwin Poon, Ph.D., Director, Behavioral Health Integration, provided an overview of the DHCS All Plan Letter (APL) 20-008 which provides guidance on mitigating health impact of secondary stress due to the COVID-19 pandemic. Dr. Poon noted that CalOptima continues to work with providers on the Adverse Childhood Experiences (ACEs) screening and the importance of mental health, including community-focused activities which includes collaboration with county behavioral health services and Be Well OC on sharing mental health resources, and educating community-based organizations on how to support members with mental health concerns due to the COVID-19 pandemic.

4. CalOptima Members Experiencing Homelessness Update

Marie J Jeannis, RN, Interim Director, Enterprise Analytics, provided an update on the transition of care for members experiencing homelessness. CalOptima's Homeless Population Clinical Report Card is reported quarterly and monitors key performance measures for this vulnerable population. The Report Card includes information on enrollment, utilization metrics and number of Clinical Field Team visits and Mobile Clinic visits. Ms. Jeannis noted that utilization of telehealth services has increased measurably due to the COVID-19 pandemic and social distancing. The Coroners' case reporting frequency has been increased to weekly (from monthly) to facilitate identification of trends. Of the reported deaths, roughly 50 to 65 percent are typically CalOptima members. Most of the deaths are not currently attributed to COVID-19, but many results regarding cause of death are pending. Ms. Jeannis also noted that Orange County has substantially increased the number of available shelter beds and locations.

Richard Sanchez, Interim Chief Executive Officer, noted that because of the COVID-19 pandemic, the linking of services has increased and the response has been the County's responsibility as part of the statewide Project Roomkey initiative, which is intended to protect the homeless by getting them off of the street. Mr. Sanchez also noted that there is talk about the County buying these hotels and turning them into permanent housing for the homeless population.

The following Information Items were accepted as presented:

5. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Committee Quarterly Report
   b. Member Trend Report

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COMMITTEE MEMBER COMMENTS

Chair Yost read comments from Director Nguyen, who was unable to attend today's meeting.

In the comments, Director Nguyen thanked staff and his fellow committee members for their work and for their focus on ensuring that CalOptima members have access to quality health care services.

Dr. Yost commented that this was also his last QAC meeting and noted he has always gravitated toward the QAC because of its focus on members and the health care services they receive. He also thanked staff for their work on behalf of CalOptima's members.

ADJOURNMENT

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

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: September 16, 2020

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 21, 2020

A Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee was held on May 21, 2020 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER
Chair Lee Penrose called the meeting to order at 2:03 p.m. Director Schoeffel led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Ria Berger; Scott Schoeffel
(All members at teleconference locations)

Members Absent: None

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

PUBLIC COMMENT
Teri Miranti, Executive Director, Government Programs, Monarch Healthcare, representing Optum Care affiliated networks which include Arta Western Medical Group, Talbert Medical Group and Monarch HealthCare -- Oral: Re: Agenda Item 5., Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2020-21 Operating Budget.

Chair Penrose noted that Agenda Item 10 is continued to a future meeting.

Chair Penrose reordered to hear Agenda Item 5 before Agenda Item 4, and to hear Agenda Item 13 right after the Consent Calendar.

MANAGEMENT REPORTS

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1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, reported that an updated Operating Budget was prepared based on the Governor's revised budget, which included deeper than anticipated Medi-Cal cuts.

Ms. Huang also provided an update on the real estate project which initially had three main components: market research for office space and parking; PACE building lease extension negotiations; and 505 building development agreement. Due to the COVID-19 pandemic, staff is planning to reprioritize the components of this project. The consultants will continue to monitor the market for office space and parking, but postpone decisions to allow management to reevaluate future office space and parking business needs. Regarding the lease for the PACE building, which expires at the end of 2021, the real estate consultants have met with the PACE management team, reviewed the current lease terms and conditions, and are ready to start negotiations with the PACE landlord. Any future proposals or recommendations related to this and other potential PACE sites will be brought back to the Board in the coming months. The last update for the real estate project is the 505 building development rights. In 2011 when CalOptima purchased the 505 building, a development agreement with the City of Orange, was in place that includes an option to construct an office building and parking structure. That agreement has been extended until October 2020. Ms. Huang noted that CalOptima management has met with the city representatives to discuss the development rights agreement. The city suggested a two-phase approach: Phase one is to extend the development rights without any modifications; Phase two would be to attempt to broaden the rights consistent with prior Board direction.

INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented an overview of the Treasurer's Report for the period January 1, 2020 through March 31, 2020. Based on a review by the Board of Directors' Investment Advisory Committee, all investments were compliant with Government Code section 53600 *et seq.,* and with CalOptima's Annual Investment Policy.

CONSENT CALENDAR

3. Approve the Minutes of the February 20, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the January 27, 2020 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

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INFORMATION ITEM

13. Health Network Rebasing Update – Milliman

Craig Keizur and Aaron Gates of CalOptima's consultant Milliman, Inc. reviewed the CalOptima rebasing process and provided an overview of the results. The goal of the project was to develop actuarially sound health care facility and professional services capitation rates. The process outline involved data analysis of millions of claim lines of data and incorporating current definitions for Category of Aid and Age/Gender. The project also involved consideration of health networks' recent facility and professional experience and included an allowance for non-medical expenses. The analysis factored in many indicators, as well as historical data and current rates. The consultants noted that CalOptima Community Network and Kaiser were not included in the rebasing exercise and reviewed the recommended rate adjustments for capitation for all categories and lines of business reviewed.

REPORTS

5. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2020-21 Operating Budget

Ms. Huang reviewed the proposed Fiscal Year (FY) 2020-21 Operating Budget, explaining that Governor Newsom's May Revise reflects the Administration's efforts to close a $54.3 billion deficit due to the COVID-19 pandemic. Part of the State's cost saving strategies included a 1.5 percent reduction in CalOptima 's current rates starting July 1, 2019 through December 31, 2020, which was part of CalOptima's bridge funding. For the 2021 calendar year, the Governor's May Revise include a proposed statewide additional 3 percent reduction in Medi-Cal rates. Ms. Huang noted that final draft rates will not be released until September or October 2020, so the FY 2020-21 budget assumes these rate reductions. The Governor's Budget proposes delaying the CalAIM initiatives and the cancellation of Medi-Cal Expansion for certain categories of members. The budget also included several trigger cuts, including a reduction in adult dental benefits and elimination of the Medi-Cal optional Community Based Adult Services (CBAS) effective January 1, 2021 and elimination the Multipurpose Senior Services Program (MSSP) effective July 2020 unless offsetting federal funding is received. Ms. Huang also noted that because many of the proposed reductions have not been finalized, both the CBAS and MSSP Programs are included in CalOptima's proposed FY2020-21 budget. Based on current assumptions, CalOptima is looking at a total projected FY 2020-21 deficit of approximately $65 million for Medi-Cal. Due to the COVID-19 pandemic and to assist providers who are also struggling, staff recommends moving forward with rebasing, but suggests that CalOptima absorb the additional reductions using reserves.

After reviewing the projections for the other lines of business, which included a projected loss of $18 million for the OneCare Program, the Finance and Audit Committee directed staff to prepare an updated version of the proposed budget with a number of adjustments to the administration budget, including scaling back dollars related to the Compensation study and funding for position upgrades and retention bonuses. FAC Members also recommended increasing the vacancy factor from 5 percent to 7 percent and to get closer to a flat administrative budget. The Committee also directed staff to look at all non-medical and non-quality items that could be cut from the budget and bring a revised draft Operating Budget back to the full Board for consideration.

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No Action Taken: ***Finance and Audit Committee members directed staff to conduct further study and make additional reductions to non-member, non-quality budget items and bring back a proposed budget to the full Board for consideration.***

4. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2020-21 Capital Budget

Ms. Huang reviewed the Fiscal Year 2020-21 Capital Budget.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors approve the CalOptima Fiscal Year (FY) 2020-21 Capital Budget and authorize the expenditures and appropriate the funds for items listed in Attachment A: Fiscal Year 2020-21 Capital Budget by Project, which shall be procured in accordance with CalOptima's Board-approved policies. (Motion carried 3-0-0)***

6. Consider Recommending Board of Directors' Ratification of Expenditures Related to Emergency Repairs for CalOptima Facilities

Ms. Huang introduced this item, noting that it related to repair of CalOptima building signage, and that the work has been completed.

Action: ***On motion of Director Penrose, seconded and carried, the Committee recommended that the Board of Directors ratify unbudgeted expenditures from existing reserves for emergency repairs at CalOptima facilities located at 505 City Parkway West in Orange (505 Building) in the amount of $19,877.55. (Motion carried 3-0-0)***

7. Consider Recommending Board of Directors' Approval of Proposed Changes to CalOptima Policy GA.3400: Annual Investments

Ms. Huang briefly introduced the item.

Action: ***On motion of Director Penrose, seconded and carried, the Committee recommended that the Board of Directors approve proposed changes to CalOptima Policy GA.3400: Annual Investments. (Motion carried 3-0-0)***

8. Consider Recommending Board of Directors' Approval of Proposed Revisions to CalOptima Finance Policies

Ms. Huang noted that these policies are being updated as part of the annual review process of policies to ensure compliance with regulatory requirements.

Action: ***On motion of Director Penrose, seconded and carried, the Committee recommended Board of Directors approval of proposed revisions to the following Finance polices: 1). CalOptima Policy FF.1006: Financial Risk Arrangement; 2). CalOptima Policy FF.1009: Health-based Risk Adjusted Capitation Payment System; 3). CalOptima Policy FF.3002: Financial***

Oversight; and 4). CalOptima Policy FF.1010: Shared Risk Pool. (Motion carried 3-0-0)

9. Consider Recommending Board of Directors' Approval of CalOptima Medi-Cal Directed Payments Policy, Modifications to Claims Administrations Policies and Procedures, and Actions Related to the CalOptima Medi-Cal Fee-For-Service Physician Services Contracts and Shared Risk Group Contracts
The Clerk noted for the record, that staff would like to strike recommendation number 4 from the recommended actions.

After discussion, the Committee approved the amended action below.

Action: ***On motion of Director Penrose, seconded and carried, the Committee Recommended that the Board of Directors: 1) Approve CalOptima Medi-Cal Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance; 2). Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2012; 3). Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2012; ~~4). Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend, as necessary and appropriate, CalOptima Medi-Cal Fee-For-Service Physician Services Contracts and Shared Risk Group Contracts to reflect that Directed Payments will be made pursuant to CalOptima Policy and Procedures;~~ and 5). Approve modifications of the following Claims Administration Policies and Procedures: A.) FF 1002: CalOptima Medi-Cal Fee Schedule B.) FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group. (Motion carried 3-0-0)*** *Amended 5/21/2020*

10. Consider Recommending Board of Directors Receive Report from Grant Thornton on Compensation and Benefits Benchmarking and Analysis with Appendix: Consider Recommending Board of Directors Adopt Actions Related to Recommendations from Grant Thornton
This item was continued to future meeting.

11. Consider Recommend Board of Directors Approve Remedial Actions Related to Health Network and Provider Overpayments Arising from Medi-Cal Member Eligibility Reporting Error
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors authorize the Chief Executive Officer (CEO)***

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to waive the recovery of additional overpayments made to Health Networks and Providers for the period of August 1, 2014 through August 30, 2018 based on a System Coding Logic Error and make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose. (Motion carried 2-0-0; Director Schoeffel recused)

INFORMATION ITEMS

12. Moss Adams 2020 Financial Audit Planning

Stacy Stelzriede, Engagement Partner, Moss Adams LLP, presented a review of the scope of services for the annual financial audit for the year ending June 30, 2020 and provided a brief overview of recent changes in accounting standards. For the FY2019-20 audit, interim fieldwork is scheduled to begin on May 20, 2020, and final fieldwork will begin on July 22, 2020. The draft audited financial statements will be presented to the Finance and Audit Committee for review at the September 2020 meeting.

Aparna Venkateswaran, Engagement Senior Manager, briefly reviewed the various reports that are produced during this audit as well as new standards that will affect CalOptima beginning in fiscal year 2021.

The following Information Items were accepted as presented:

14. March 2020 Financial Summary
15. CalOptima Information Security Update
16. Quarterly Operating and Capital Budget
17. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Whole-Child Model Financial Report
    c. Reinsurance Report
    d. Health Network Financial Report
    e. Contingency Contract Report

COMMITTEE MEMBER COMMENTS

Committee Chair Lee Penrose noted that this is his last Finance and Audit Committee meeting and thanked staff for their work, adding he was glad to be a part of the FAC since joining the CalOptima Board of Directors.

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 5:02 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: September 17, 2020

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MINUTES

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

August 13, 2020

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, August 13, 2020 via teleconference using GoTo Webinar technology 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 8:02 a.m. and Teri Miranti, PAC Vice Chair led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Amin Alpesh, M.D.; Anjan Batra, M.D.; Jennifer Birdsall; Tina Bloomer, MHNP; Donald Bruhns; Andrew Inglis, M.D.; Jena Jensen; Peter Korchin; Junie Lazo-Pearson, Ph.D.; Alexander Rossel; Loc Tran, PharmD.; Christy Ward

Members Absent: John Kelly, M.D.

Others Present: Richard Sanchez, Interim Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Candice Gomez, Executive Director, Program Implementation; Betsy Ha, Executive Director, Quality and Population Health Population Management; Michelle Laughlin, Executive Director, Network Operations; TC Roady, Director Regulatory Affairs; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant.

Chair Nishimoto welcomed the new PAC members Alpesh Amin, M.D., Alex Rossel and Christy Ward to the Committee. The new members were appointed at the June 4, 2020 Board and began their terms on July 1, 2020.

MINUTES

Approve the Minutes of the June 11, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee.

Action: ***On motion of Member Batra, seconded and carried, the Committee approved the minutes of the June 11, 2020 regular meeting. (Motion carried 14-0-0; Member Kelly absent)***

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PUBLIC COMMENTS

There were no public comments.

REPORTS

Consider Recommendation of PAC Chair and Vice Chair

PAC received a letter of interest from Junie Lazo-Pearson, Ph.D., Behavioral Health Representative, for the Chair position. After receiving no nominations from the floor, Vice Chair Miranti requested a motion to recommend Dr. Lazo-Pearson as the PAC Chair for FY 2020-22.

Action: ***On motion of Member Ward, seconded and carried, the Committee approved the recommendation of the PAC Chair (Motion carried 13-0-1; Member Lazo-Pearson abstained; Member Kelly Absent)***

PAC also received a letter of interest from current PAC Chair John Nishimoto, O.D. the Non Physician Medical Practitioner Representative, for the Vice Chair position. There were no nominations from the floor. Vice Chair Miranti asked for a motion to recommend current Chair Nishimoto as PAC Vice Chair for 2020-22.

Action: ***On motion of Member Batra, seconded and carried, the Committee approved the recommendation of the PAC Vice Chair (Motion carried 13-0-1; Chair Nishimoto abstained; Member Kelly absent)***

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Interim Chief Executive Officer (CEO), discussed the Department of Health Care Services (DHCS) Medi-Cal expansion rate reductions which may be implemented as soon as January 1, 2021, which elicited much discussion from the members. He noted that more information will be forthcoming from DHCS and that he would keep the PAC updated.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, welcomed the new PAC members to the Committee and provided a verbal update on the annual Qualified Medicare Beneficiary (QMB) outreach program and noted that letters had been sent out to members who have Part B Medicare but also qualify for Part A. Ms. Khamseh also mentioned that all Medi-Cal Managed Care Plans including CalOptima would need to apply for the Annual Health Network Certification by March 2021, which would become effective July 2021. Ms. Khamseh introduced Michelle Laughlin, Executive Director, Network Operations, who provided a brief report on CalOptima's plan for network certification.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, reviewed the COVID-19 numbers for Orange County. He noted that testing capabilities have increased and that new testing sites have opened throughout the County, with a high volume site at the Anaheim Convention Center. Dr. Ramirez

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also provided an update on the Health Home Program Phase 2, which became effective July 1, 2020 and the Hospital Data Exchange Program. Dr. Ramirez updated the committee on the status of the virtual care or telehealth options that are available to CalOptima and its members. He noted that over 200,000 members have used this option. Members Alpesh and Batra both offered their assistance to CalOptima with the virtual care/telehealth implementation based on their related experience at the University of California Irvine Medical Center (UCI) and agreed to provide information to Dr. Ramirez on this initiative.

INFORMATION ITEMS

Homeless Health Initiative Update

Dr. Ramirez and Candice Gomez, Executive Director, Program Implementation, presented on the Homeless Health Initiative. Ms. Gomez discussed the Homeless Health program goals, the Clinical Field Teams (CFT) pilot design, the CFT's structure, scheduled services at shelters, hotspots and the referral source role. Dr. Ramirez provided an overview of the roles of CalOptima and the health networks. He also provided CFT details including number of calls dispatched, number of patients treated, on-call visit locations, and referral sources.

Federal and State Legislative Update

TC Roady, Director, Regulatory Affairs, provided a verbal update on the California State Budget for the 2020-21 fiscal year. Mr. Roady noted that the COVID-19 pandemic has contributed significantly to this year's budget deficit as well as to the anticipated growth in Medi-Cal enrollment. Mr. Roady also mentioned the Pharmacy carve out, which is slated to become effective January 1, 2021.

PAC Member Updates

Chair Nishimoto reminded the members about the upcoming October 8, 2020 Joint Advisory Committee Meeting and noted that the chairs and vice chairs from each committee would be meeting via conference call to review possible agenda items. Chair Nishimoto also thanked the members for their support during the last two years and noted that this was his final meeting as the PAC Chair.

ADJOURNMENT

Chair Nishimoto announced that the next PAC meeting is scheduled for Thursday, September 10, 2020 at 8:00 a.m.

Hearing no further business, Chair Nishimoto adjourned the meeting at 10:05 a.m.

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

Approved: September 10, 2020

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

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

Recommended Action

Recommend reappointment of David Young to the Board of Directors' Investment Advisory Committee for a two-year term beginning October 1, 2020.

Background

At a Special Meeting of the CalOptima Board of Directors held on September 10, 1996, the Board authorized the creation of the IAC, established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the Committee.

When creating the IAC, the Board stipulated that the Committee would consist of five (5) members, one (1) member would automatically serve by virtue of his or her position as CalOptima's Chief Financial Officer. The remaining four (4) members would be Orange County residents who possessing experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima on its investment activities.

Discussion

The following candidate recommended for reappointment has consistently provided leadership and service to CalOptima's investment strategies through his participation as a member of the IAC.

David Young has served as a member of the IAC since June 4, 2009. Mr. Young is founder and Chief Executive Officer of Anfield Group, LLC, a financial consulting and investment advisory firm. In 2008, he retired as Executive Vice President and Account Manager of Pacific Investment Management Company (PIMCO) and rejoined the University of California, Irvine (UCI), Paul Merage School of Business as Adjunct Professor. From 1999 to 2006, he was head of PIMCO's account management group in London. Prior to that, Mr. Young held positions at Analytic Investment Management, Smith Barney, and Harris Upham. He has over 30 years of investment experience and is a Certified Financial Advisor (CFA). In addition, Mr. Young is a member of the CFA Society of Orange County Board of Directors, and the chair of its Investment Committee. He also is board member of the UCI Paul Merage School of Business Center for Investment & Wealth Management Executive Committee and chairs its Journal editorial board. Mr. Young received his undergraduate degree and M.B.A. from the University of California, Irvine. His current term expires on October 7, 2020.

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At its July 20, 2020, meeting, the IAC recommended that the Finance and Audit Committee recommend that the Board reappoint David Young to the IAC.

Fiscal Impact

There is no fiscal impact. Individuals appointed to the IAC are responsible for assisting CalOptima in meeting the objectives of CalOptima's annual investment policy, including preservation of capital, meeting the agency's liquidity needs, and obtaining an acceptable return on investment of available funds.

Rationale for Recommendation

The individual recommended for reappointment to CalOptima's IAC has extensive experience that meets or exceeds the specified qualifications. In addition, the candidate has already provided outstanding service as a member of the IAC.

Concurrence

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

Attachments

None

/s/ Richard Sanchez *09/23/2020*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Meeting of the CalOptima Board of Directors

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

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

Recommended Action
Recommend appointment of the following two individuals to the Board's Investment Advisory Committee (IAC) for two-year terms beginning October 1, 2020:

1. Collen Clark; and
2. David Hutchison.

Background
At a Special Meeting of the CalOptima Board of Directors held on September 10, 1996, the Board authorized the creation of the CalOptima IAC, established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the Committee.

When creating the IAC, the Board stipulated that the Committee would consist of five (5) members; one (1) member would automatically serve by virtue of his or her position as CalOptima's Chief Financial Officer. The remaining four (4) members would be Orange County residents who possess experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima on its investment activities.

Discussion
The candidates recommended for appointment are expected to provide leadership and service to CalOptima's investment oversight through their participation as IAC members. They also have proven leadership and expertise in finance and accounting.

As part of the process of filling the vacancies, staff conducted a recruitment process intended to solicit a diverse applicant pool of candidates. The recruitment included an announcement on the CalOptima website, referrals from the Board of Directors and IAC Committee Members, and an advertisement in the local business journal. Staff received applications from three interested candidates and submitted them to the IAC Nominations Ad Hoc Committee for review and recommendation. Prior to conducting virtual interviews in early June 2020, the Ad Hoc Committee members evaluated each of the applications submitted. Based on this process, the Ad Hoc Committee, comprised of IAC Members Patrick Moore and Nancy Huang, recommended two candidates move forward to the full IAC for consideration. At its July 20, 2020, meeting, the IAC adopted the Ad Hoc Committee's

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recommendation, and recommended that the Finance and Audit Committee recommend that the Board appoint the candidates to the IAC.

Candidates:
Colleen Clark*
David Hutchison*
Annie Tran

Collen Clark has over 27 years of experience and a knowledge of public finance, investments, accounting and government and legislative processes. Ms. Clark was the Director of Public Finance for the County of Orange and worked as the Deputy Chief Executive Officer and Chief Financial Officer for the Orange County Great Park. She has held finance positions at the Transportation Corridor Agency in Irvine and is a former Certified Public Accountant.

David Hutchinson currently works for Triad Investment Management, where he is a Partner and Portfolio Manager. Mr. Hutchinson has over 15 years of experience and has previously held positions as President and Portfolio Manager for Hutchison Financial, Investment Strategist for the Chamberlin Group, and as a Senior Equity Analyst for Insight Capital Research & Management.

Annie Tran currently works for Charles Fish Investments as a Portfolio Manager. She has over 10 years of experience and previously worked as an Analyst for US Bank, as well as an Investment Analyst intern for the City of Orange.

Fiscal Impact
There is no fiscal impact. Individuals appointed to the IAC are responsible for assisting CalOptima in meeting the objectives of CalOptima's annual investment policy, including preservation of capital, meeting the agency's liquidity needs, and obtaining an acceptable return on investment of available funds.

Rationale for Recommendation
The individuals recommended for appointment to CalOptima's IAC have extensive experience that meets or exceeds the specified qualifications.

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

Attachments
None

/s/ Richard Sanchez — *09/23/2020*
Authorized Signature — **Date**

*Indicates Nominations Ad Hoc Committee and Investment Advisory Committee Recommendations

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Belinda Abeyta, Executive Director, Operations, 714-246-8400

Recommended Actions

1. The OneCare Connect Member Advisory Committee (OCC MAC) recommends the appointments for terms ending June 30, 2022 of:
    a. Patty Mouton as the OCC MAC Chair; and
    b. Keiko Gamez as the OCC MAC Vice Chair.
2. The Whole-Child Model Family Advisory Committee (WCM FAC) recommends the appointments for terms ending June 30, 2022 of:
    a. Kristen Rogers as the WCM FAC Chair; and
    b. Brenda Deeley as WCM FAC Vice Chair.

Background

OCC MAC: The CalOptima Board of Directors established the OCC MAC by Resolution No. 15-0205 on February 5, 2015, to serve solely in an advisory capacity providing input and recommendations concerning the OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan). The OCC MAC is comprised of 15 voting members, including two standing members: one representative each from the Orange County Health Care Agency and the Orange County Social Services Agency.

WCM FAC: The CalOptima Board of Directors established the WCM FAC by Resolution No. 17-1102-01 on November 2, 2017, to serve solely in an advisory capacity providing input and recommendations concerning the Whole-Child Model program. The WCM FAC is comprised of 11 voting members, seven of whom are to be designated as family representatives and the remaining four designated as community seats representing the interests of children receiving CCS services.

Pursuant to Resolution No. 20-0806, the CalOptima Board of Directors is responsible for the appointment of the OCC MAC and WCM FAC Chairs and Vice Chairs bi-annually from among appointed members. The Chair and Vice Chair may serve a two-year term.

Discussion

In the month leading up to the August 25, 2020, and August 27, 2020, meetings, members of the OCC MAC and WCM FAC were asked to submit letters of interest for the Chair and Vice Chair positions to the Advisory Committees' staff.

For the OCC MAC, Patty Mouton submitted a letter of interest for the Chair, and Keiko Gamez submitted a letter of interest for the Vice Chair. At their August 27, 2020, meeting, OCC MAC members voted to recommend Patty Mouton as OCC MAC Chair and Keiko Gamez as the Vice Chair.

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WCM FAC members Kristen Rogers submitted a letter of interest for the WCM FAC Chair and Brenda Deeley submitted a letter of interest for the Vice Chair. At their August 25, 2020, meeting, WCM FAC members voted to recommend Kristen Rogers as the WCM FAC Chair and Brenda Deeley as the WCM FAC Vice Chair.

The recommended candidates for OCC MAC Chair and Vice Chair are as follows with information from their letters of interest:

OCC MAC Chair Candidate
Patty Mouton*

Patty Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County and has worked in the area of health care for older adults for 17 years. Ms. Mouton oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy-forming activities. In addition, Ms. Mouton speaks to community groups about issues of medical coverage and defining the continuum of care. Ms. Mouton has served on the OCC MAC since 2015 and is currently serving as the Chair for the OCC MAC.

OCC MAC Vice Chair Candidate
Keiko Gamez*

Keiko Gamez is a OneCare Connect member who is interested in serving others. She has experienced many difficulties in her life, but overcoming these experiences provides her the opportunity to make valuable contributions to the committee. She describes herself as a problem-solver with skills to resolve difficult tasks. Ms. Gamez has served on the OCC MAC since 2018.

The recommended candidates for WCM FAC Chair and Vice Chair are as follows with information from their letters of interest:

WCM FAC Chair Candidate
Kristen Rogers*

Kristen Rogers is a parent of a CalOptima member and CCS beneficiary. Ms. Rogers is an active volunteer at CHOC and has served on the WCM FAC since 2018. In March of 2019, Ms. Rogers was appointed to the California Children Services Advisory Group as a representative of CalOptima and the WCM FAC.

WCM FAC Vice Chair Candidate
Brenda Deeley*

Brenda Deeley is a parent of a CalOptima member and CCS beneficiary. As a public relations, public affairs and community relations strategist, Ms. Deeley has used her professional skills to work in advocacy of her daughter. She is currently the CEO of Brenda Deeley PR, LLC., and has CHOC

*Indicates recommended candidates

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Children's Hospital and Pomona Valley Hospital Medical Center among her clients. Ms. Deeley has served on the WCM FAC since 2019.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Open nominations were held at the August 27, 2020, OCC MAC meeting and the August 25, 2020, WCM FAC meeting based on the letters of interest received. During the meetings, there were no additional nominations made from the floor. The OCC MAC and the WCM FAC forward the recommended Chairs and Vice Chairs to the Board of Directors for consideration and appointment.

Concurrence
OneCare Connect Member Advisory Committee
Whole-Child Model Family Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez *09/23/2020*
Authorized Signature **Date**

*Indicates recommended candidates

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Belinda Abeyta, Executive Director, Operations, 714-246-8400

Recommended Action

The OneCare Connect Member Advisory Committee recommends the appointment of Meredith Chillemi as the OneCare Connect Member Advisory Committee (OCC MAC) Long-Term Care Facility Representative to serve a two-year term ending June 30, 2022.

Background

The CalOptima Board of Directors established the OneCare Connect Member Advisory Committee (OCC MAC) by Resolution No. 15-0205 on February 5, 2015 to serve solely in an advisory capacity providing input and recommendations concerning the OneCare Connect program. The OCC MAC is comprised of ten voting members, seven of whom represent community seats and three of whom are OneCare Connect members or family of members. There are also four non-voting members representing Orange County agencies. OCC MAC voting members serve two-year terms, with no limit on the number of terms a representative may serve.

Discussion

Staff conducted a comprehensive outreach, including sending notifications to community-based organizations (CBOs), posting recruitment materials on the CalOptima website and staff also presented about the Board Advisory Committees at a Community Alliances Forum to enhance recruitment efforts.

The OCC MAC Nominations Ad Hoc Subcommittee, composed of OCC MAC committee Josefina Diaz, Sara Lee and Patty Mouton, met on August 18, 2020, to evaluate the only applicant for the Long-Term Care Facility seat. The OCC MAC Nominations Ad Hoc recommended Meredith Chillemi as the OCC MAC Long-Term Care Facility Representative.

At the August 25, 2020 OCCMAC meeting, members accepted the recommended candidate as proposed by the Nominations Ad Hoc and requested that the proposed candidate be forwarded to the CalOptima Board of Directors for consideration.

The recommended candidate for OCC MAC Long-Term Care Facility Representative seat is:

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Long-Term Services and Supports Representative Candidate
Meredith Chillemi

Meredith Chillemi is the LifeSTEPS Director of Aging and Education Services where she provides direct service to CalOptima Dual eligible older adults residing in affordable housing communities in Westminster, Brea and San Clemente. As a lead at LifeSTEPS, she guides programs at 10 senior affordable housing apartment communities in Orange County and regularly collaborates with community-based adult services, Senior Centers, the Office on Aging and serves on the County of Orange Senior Citizens Advisory Council Health and Nutrition Committee.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy, the OCC MAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The OCC MAC met to discuss the Ad Hoc's recommended candidate and concurred with the subcommittee's recommended candidate. The OCC MAC forwards the recommended candidate to the Board of Directors for consideration.

Concurrence
OneCare Connect Member Advisory Committee Nominations Ad Hoc
OneCare Connect Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez — *09/23/2020*
Authorized Signature — **Date**

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Financial Summary

August 31, 2020

Board of Directors Meeting
October 1, 2020

Nancy Huang, Chief Financial Officer

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FY 2020-21: Consolidated Enrollment

August 2020 MTD

Overall enrollment was 784,741 members

- Actual higher than budget 5,805 or 0.7%
  - Medi-Cal favorable to budget 5,250 or 0.7% due to prior year retroactive enrollment
    - Medi-Cal Expansion (MCE) favorable variance of 6,864
    - Long-Term Care (LTC) favorable variance of 2,667
    - Seniors and Persons With Disabilities (SPD) favorable variance of 2,305
    - Breast and Cervical Cancer Treatment Program (BCCTP) favorable variance of 21
    - Temporary Assistance for Needy Families (TANF) unfavorable variance of 3,940
    - Whole-Child Model (WCM) unfavorable variance of 2,667

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FY 2020-21: Consolidated Enrollment (cont.)

August 2020 MTD

- OneCare Connect favorable to budget 434 or 3.1%
- OneCare favorable to budget 145 or 10.5%
- PACE unfavorable to budget 24 or 5.9%

- 16,996 increase or 2.2% from July, 4,015 due to prior year retroactive enrollment
  - Medi-Cal increase of 16,923
  - OneCare Connect increase of 76
  - OneCare decrease of 2
  - PACE decrease of 1

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FY 2020-21: Consolidated Enrollment (cont.)

August 2020 YTD

Overall enrollment was 1,552,486 member months

- Actual higher than budget 3,038 or 0.2%
  - Medi-Cal favorable variance to budget 2,024 or 0.1%
    - MCE favorable variance of 9,994
    - SPD favorable variance of 3,918
    - LTC favorable variance of 2,592
    - BCCTP favorable variance of 38
    - TANF unfavorable variance of 8,993
    - WCM unfavorable variance of 5,525
  - OneCare Connect favorable to budget 765 or 2.7%
  - OneCare favorable to budget 292 or 10.6%
  - PACE unfavorable to budget 43 or 5.3%

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FY 2020-21: Consolidated Revenues

August 2020 MTD

- Actual lower than budget $21.8 million or 6.8%
  - Medi-Cal unfavorable to budget $24.1 million or 8.4%
    - Favorable volume related variance of $2.0 million
    - Unfavorable price related variance of $26.1 million
      - $37.8 million of revenue due to Governor's budget changes for the eighteen (18)-months bridge period, including:
        - Gross Medical Expenditures (GME) risk corridor reserve
        - 1.5% reduction to fiscal year (FY) 2021 capitation rates for certain aid code categories
      - $5.6 million of WCM revenue
      - $2.9 million of Behavioral Health Treatment (BHT) revenue
      - Offset by $22.7 million of Coordinated Care Initiative (CCI) revenue due to new calendar year (CY) 2020 rate true-up in August

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FY 2020-21: Consolidated Revenues (cont.)

August 2020 MTD

- OneCare Connect favorable to budget $2.3 million or 8.9%
  - Favorable volume related variance of $0.8 million
  - Favorable price related variance of $1.5 million due to CCI CY 2020 rate true-up revenue
- OneCare favorable to budget $0.1 million or 7.2%
  - Favorable volume related variance of $0.2 million
  - Unfavorable price related variance of $0.1 million
- PACE unfavorable to budget $0.1 million or 3.6%
  - Unfavorable volume related variance of $0.2 million
  - Favorable price related variance of $0.1 million

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FY 2020-21: Consolidated Revenues (cont.)

August 2020 YTD

- Actual lower than budget $30.0 million or 4.7%
  - Medi-Cal unfavorable to budget $31.2 million or 5.4%
    - Favorable volume variance of $0.8 million
    - Unfavorable price variance of $31.9 million
      - $40.6 million of revenue due to Governor's budget changes, including:
        - GME risk corridor reserve
        - 1.5% reduction to FY 2021 capitation rates for certain aid code categories
      - $11.3 million of WCM revenue
      - $3.2 million of BHT revenue
      - Offset by $22.7 million of CCI revenue due to CY 2020 rate increase

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FY 2020-21: Consolidated Revenues (cont.)

August 2020 YTD

- OneCare Connect favorable to budget $0.9 million or 1.8%
  - Favorable volume variance of $1.4 million
  - Unfavorable price variance of $0.5 million
- OneCare favorable to budget $0.5 million or 14.2%
  - Favorable volume variance of $0.4 million
  - Favorable price variance of $0.1 million
- PACE unfavorable to budget $0.2 million or 3.1%
  - Unfavorable volume variance of $0.3 million
  - Favorable price variance of $0.1 million

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FY 2020–21: Consolidated Medical Expenses

August 2020 MTD

- Actual lower than budget $21.0 million or 6.8%
  - Medi-Cal favorable variance of $19.9 million or 7.1%
    - Unfavorable volume related variance of $1.9 million
    - Favorable price related variance of $21.8 million primarily due to decrease in utilization during COVID-19 pandemic
      - Facilities Claims expense favorable variance of $13.1 million
      - Provider Capitation expense favorable variance of $8.8 million
      - Professional Claims expense favorable variance of $5.0 million
      - Medical Management expense favorable variance of $1.2 million
      - Offset by Managed Long Term Services and Supports (MLTSS) expense unfavorable variance of $4.8 million due to the 10% reimbursement rate increase and Prescription Drugs expense unfavorable variance of $1.5 million

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FY 2020-21: Consolidated Medical Expenses (cont.)

August 2020 MTD

- OneCare Connect favorable variance of $1.0 million or 3.9%
  - Unfavorable volume related variance of $0.8 million
  - Favorable price related variance of $1.8 million
- OneCare unfavorable variance of $0.3 million or 16.8 %
  - Unfavorable volume related variance of $0.2 million
  - Unfavorable price related variance of $0.1 million
- PACE favorable variance of $0.4 million or 12.0%
  - Favorable volume related variance of $0.2 million
  - Favorable price related variance of $0.2 million

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FY 2020-21: Consolidated Medical Expenses (cont.)

August 2020 YTD

- Actual lower than budget $27.5 million or 4.4%
  - Medi-Cal favorable variance of $28.0 million or 5.0%
    - Unfavorable volume variance of $0.8 million
    - Favorable price variance of $28.8 million primarily due to decrease in utilization during COVID-19 pandemic
      - Facilities Claims expense favorable variance of $16.2 million
      - Provider Capitation expense favorable variance of $12.7 million
      - Professional Claims expense favorable variance of $6.0 million
      - Medical Management expense favorable variance of $1.7 million
      - Offset by Prescription Drugs expense unfavorable variance of $4.4 million
      - MLTSS expense unfavorable variance of $3.6 million due to the 10% reimbursement rate increase

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FY 2020-21: Consolidated Medical Expenses (cont.)

August 2020 YTD

- OneCare Connect unfavorable variance of $1.1 million or 2.1%
  - Unfavorable volume variance of $1.4 million
  - Favorable price variance of $0.3 million
- OneCare unfavorable variance of $0.4 million or 13.1%
  - Unfavorable volume variance of $0.3 million
  - Unfavorable price variance of $0.1 million
- PACE favorable variance of $0.9 million or 15.3%
  - Favorable volume variance of $0.3 million
  - Favorable price variance of $0.6 million

Medical Loss Ratio (MLR)

August 2020 MTD:	Actual : 97.4%	Budget: 97.3%
August 2020 YTD:	Actual: 97.5%	Budget: 97.2%

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FY 2020-21:Consolidated Administrative Expenses

August 2020 MTD

- Actual lower than budget $2.5 million or 19.4%
  - Salaries, wages and benefits: favorable variance of $0.9 million
  - Other categories: favorable variance of $1.6 million

August 2020 YTD

- Actual lower than budget $3.8 million or 14.6%
  - Salaries, wages and benefits: favorable variance of $1.0 million
  - Other categories: favorable variance of $2.8 million

Administrative Loss Ratio (ALR)

August 2020 MTD: Actual: 3.4% Budget: 4.0%

August 2020 YTD: Actual: 3.6% Budget: 4.1%

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FY 2020-21: Change in Net Assets

August 2020 MTD

- Change in net assets is ($2.0) million, favorable to budget $0.7 million
  - Lower than budgeted revenue of $21.8 million
  - Lower than budgeted medical expenses of $21.0 million
  - Lower than budgeted administrative expenses of $2.5 million
  - Lower than budgeted investment and other income of $0.9 million

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FY 2020–21: Change in Net Assets (cont.)

August 2020 YTD

- Change in net assets is ($5.2) million, favorable to budget $0.5 million
  - Lower than budgeted revenue of $30.0 million
  - Lower than budgeted medical expenses of $27.5 million
  - Lower than budgeted administrative expenses of $3.8 million
  - Lower than budgeted investment and other income of $0.8 million

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Enrollment Summary: August 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
113,120	110,815	2,305	2.1%	SPD	225,510	221,592	3,918	1.8%
510	489	21	4.3%	BCCTP	1,020	982	38	3.9%
291,791	301,672	(9,881)	(3.3%)	TANF Child	580,029	599,025	(18,996)	(3.2%)
96,712	90,771	5,941	6.5%	TANF Adult	190,284	180,281	10,003	5.5%
6,174	3,507	2,667	76.0%	LTC	9,604	7,012	2,592	37.0%
250,724	243,860	6,864	2.8%	MCE	494,883	484,889	9,994	2.1%
9,265	11,932	(2,667)	(22.4%)	WCM	18,339	23,864	(5,525)	(23.2%)
768,296	**763,046**	**5,250**	**0.7%**	**Medi-Cal Total**	**1,519,669**	**1,517,645**	**2,024**	**0.1%**
14,541	**14,107**	**434**	**3.1%**	**OneCare Connect**	**29,006**	**28,241**	**765**	**2.7%**
1,523	**1,378**	**145**	**10.5%**	**OneCare**	**3,048**	**2,756**	**292**	**10.6%**
381	**405**	**(24)**	**(5.9%)**	**PACE**	**763**	**806**	**(43)**	**(5.3%)**
784,741	**778,936**	**5,805**	**0.7%**	**CalOptima Total**	**1,552,486**	**1,549,448**	**3,038**	**0.2%**

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Financial Highlights: August 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
784,741	778,936	5,805	0.7%	Member Months	1,552,486	1,549,448	3,038	0.2%
297,355,487	319,187,852	(21,832,365)	(6.8%)	Revenues	606,061,698	636,045,498	(29,983,800)	(4.7%)
289,485,870	310,483,595	20,997,725	6.8%	Medical Expenses	590,959,455	618,443,697	27,484,242	4.4%
10,238,802	12,698,676	2,459,874	19.4%	Administrative Expenses	22,006,785	25,782,879	3,776,094	14.6%
(2,369,185)	**(3,994,419)**	**1,625,234**	**40.7%**	**Operating Margin**	**(6,904,543)**	**(8,181,078)**	**1,276,535**	**15.6%**
361,648	1,250,000	(888,352)	(71.1%)	Non Operating Income (Loss)	1,748,235	2,500,000	(751,765)	(30.1%)
(2,007,538)	**(2,744,419)**	**736,881**	**26.9%**	**Change in Net Assets**	**(5,156,308)**	**(5,681,078)**	**524,770**	**9.2%**
97.4%	97.3%	(0.1%)		Medical Loss Ratio	97.5%	97.2%	(0.3%)	
3.4%	4.0%	0.5%		Administrative Loss Ratio	3.6%	4.1%	0.4%	
(0.8%)	(1.3%)	0.5%		Operating Margin Ratio	(1.1%)	(1.3%)	0.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: August 2020 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(5.1)	(3.2)	(1.9)	Medi-Cal	(6.1)	(6.5)	0.3
2.4	(1.1)	3.5	OCC	(2.0)	(2.1)	0.2
(0.1)	0.0	(0.1)	OneCare	0.2	0.1	0.1
0.4	0.2	0.2	PACE	1.1	0.3	0.7
(2.4)	**(4.0)**	**1.6**	**Operating**	**(6.9)**	**(8.2)**	**1.3**
0.4	1.3	(0.9)	Inv./Rental Inc, MCO tax	1.7	2.5	(0.8)
0.4	**1.3**	**(0.9)**	**Non-Operating**	**1.7**	**2.5**	**(0.8)**
(2.0)	**(2.7)**	**0.7**	**TOTAL**	**(5.2)**	**(5.7)**	**0.5**

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Consolidated Revenue & Expenses: August 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	508,307	250,724	9,265	768,296	14,541	1,523	381	784,741
REVENUES								
Capitation Revenue	154,637,413	$ 91,400,719	$ 18,080,495	$ 264,118,627	$ 28,250,638	$ 1,811,539	$ 3,174,683	$ 297,355,487
Total Operating Revenue	154,637,413	91,400,719	18,080,495	264,118,627	28,250,638	1,811,539	3,174,683	297,355,487
MEDICAL EXPENSES								
Provider Capitation	33,755,576	43,015,882	10,874,615	87,646,073	10,877,619	479,386		99,003,079
Facilities	22,641,481	20,414,401	2,182,940	45,238,822	3,963,859	487,678	866,545	50,556,904
Professional Claims	18,523,166	8,564,308	1,015,499	28,102,973	820,577	58,419	590,431	29,572,399
Prescription Drugs	20,143,633	24,459,693	3,921,905	48,525,231	6,099,932	681,919	261,489	55,568,571
MLTSS	39,619,953	3,189,045	2,939,547	45,748,545	1,307,600	15,139	2,934	47,074,218
Medical Management	2,124,382	1,243,395	274,468	3,642,245	990,339	38,035	759,740	5,430,360
Quality Incentives	786,971	464,672	31,179	1,282,822	215,505		4,763	1,503,089
Reinsurance & Other	352,996	184,682	10,655	548,333	119,829		109,088	777,250
Total Medical Expenses	137,948,158	101,536,078	21,250,808	260,735,044	24,395,259	1,760,577	2,594,990	289,485,870
Medical Loss Ratio	89.2%	111.1%	117.5%	98.7%	86.4%	97.2%	81.7%	97.4%
GROSS MARGIN	**16,689,255**	**(10,135,360)**	**(3,170,313)**	**3,383,583**	**3,855,379**	**50,962**	**579,694**	**7,869,617**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,147,488	710,932	74,231	139,910	7,072,561
Professional fees				190,132	5,334	16,000	123	211,589
Purchased services				566,305	73,474	8,561	438	648,777
Printing & Postage				214,189	67,715	5,274	310	287,488
Depreciation & Amortization				291,674			2,018	293,692
Other expenses				1,306,426	36,028	205	4,116	1,346,775
Indirect cost allocation & Occupancy				(214,879)	553,492	35,185	4,122	377,920
Total Administrative Expenses				8,501,334	1,446,975	139,456	151,037	10,238,802
Admin Loss Ratio				3.2%	5.1%	7.7%	4.8%	3.4%
INCOME (LOSS) FROM OPERATIONS				(5,117,752)	2,408,404	(88,494)	428,656	(2,369,185)
INVESTMENT INCOME								865,517
TOTAL MCO TAX				(505,556)				(505,556)
TOTAL GRANT INCOME				1,575				1,575
OTHER INCOME				112				112
CHANGE IN NET ASSETS				**$ (5,621,621)**	**$ 2,408,404**	**$ (88,494)**	**$ 428,656**	**$ (2,007,538)**
BUDGETED CHANGE IN NET ASSETS				(3,177,210)	(1,054,587)	45,116	192,262	(2,744,419)
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,444,411)	$ 3,462,991	$ (133,610)	$ 236,394	$ 736,881

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Consolidated Revenue & Expenses: August 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,006,447	494,883	18,339	1,519,669	29,006	3,048	763	1,552,486
REVENUES								
Capitation Revenue	302,323,119	$ 204,597,932	$ 36,030,961	$ 542,952,012	$ 52,896,867	$ 3,863,114	$ 6,349,704	$ 606,061,698
Total Operating Revenue	302,323,119	204,597,932	36,030,961	542,952,012	52,896,867	3,863,114	6,349,704	606,061,698
MEDICAL EXPENSES								
Provider Capitation	71,415,436	84,710,230	21,954,010	178,079,676	22,149,663	1,036,304		201,265,644
Facilities	48,043,050	44,867,777	6,271,680	99,182,507	8,934,562	916,161	1,512,517	110,545,746
Professional Claims	38,735,660	18,320,249	2,366,803	59,422,711	1,888,469	154,170	1,111,897	62,577,247
Prescription Drugs	41,603,533	49,531,187	6,247,363	97,382,083	12,955,347	1,162,724	533,063	112,033,218
MLTSS	74,501,838	6,008,092	4,385,483	84,895,413	3,154,204	66,834	89	88,116,540
Medical Management	4,732,515	2,706,732	583,802	8,023,049	2,155,884	73,456	1,596,460	11,848,849
Quality Incentives	1,564,435	919,346	62,721	2,546,501	427,920		9,538	2,983,959
Reinsurance & Other	706,961	368,039	21,666	1,096,667	256,040		235,546	1,588,253
Total Medical Expenses	281,303,428	207,431,652	41,893,528	530,628,607	51,922,089	3,409,649	4,999,109	590,959,455
Medical Loss Ratio	93.0%	101.4%	116.3%	97.7%	98.2%	88.3%	78.7%	97.5%
GROSS MARGIN	**21,019,691**	**(2,833,719)**	**(5,862,567)**	**12,323,405**	**974,778**	**453,465**	**1,350,595**	**15,102,243**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				13,374,453	1,464,705	176,515	274,383	15,290,055
Professional fees				480,918	10,667	32,000	163	523,748
Purchased services				1,288,170	166,905	9,387	3,041	1,467,504
Printing & Postage				462,845	131,330	11,427	4,572	610,174
Depreciation & Amortization				586,519			4,107	590,627
Other expenses				2,698,760	78,572	205	5,521	2,783,059
Indirect cost allocation & Occupancy				(443,954)	1,106,984	70,370	8,220	741,620
Total Administrative Expenses				18,447,712	2,959,162	299,904	300,007	22,006,785
Admin Loss Ratio				3.4%	5.6%	7.8%	4.7%	3.6%
INCOME (LOSS) FROM OPERATIONS				(6,124,307)	(1,984,384)	153,561	1,050,587	(6,904,543)
INVESTMENT INCOME								3,016,178
TOTAL MCO TAX				(1,274,993)				(1,274,993)
TOTAL GRANT INCOME				6,862				6,862
OTHER INCOME				187				187
CHANGE IN NET ASSETS				**$ (7,392,250)**	**$ (1,984,384)**	**$ 153,561**	**$ 1,050,587**	**$ (5,156,308)**
BUDGETED CHANGE IN NET ASSETS				(6,466,805)	(2,143,450)	89,324	339,853	(5,681,078)
VARIANCE TO BUDGET - FAV (UNFAV)				$ (925,445)	$ 159,066	$ 64,237	$ 710,734	$ 524,770

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Balance Sheet: As of August 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$361,974,043	Accounts Payable	$98,432,577
Investments	785,112,848	Medical Claims liability	893,811,200
Capitation receivable	347,726,085	Accrued Payroll Liabilities	15,949,699
Receivables - Other	46,737,741	Deferred Revenue	22,338,791
Prepaid expenses	6,927,548	Deferred Lease Obligations	160,858
		Capitation and Withholds	142,027,078
Total Current Assets	**1,548,478,265**	**Total Current Liabilities**	**1,172,720,202**
Capital Assets			
Furniture & Equipment	39,890,502		
Building/Leasehold Improvements	10,077,966		
505 City Parkway West	51,620,226		
	101,588,694		
Less: accumulated depreciation	(54,324,913)		
Capital assets, net	47,263,780	Other (than pensions) post employment benefits liability	25,899,469
Other Assets		Net Pension Liabilities	26,645,035
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	57,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,225,264,706**
Cash and Cash Equivalents	3,104,429		
Long-term Investments	583,910,510	**Deferred Inflows**	
Total Board-designated Assets	587,014,939	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
		Change in Assumptions	3,728,725
Total Other Assets	644,513,852	OPEB Changes in Assumptions	1,638,000
		Net Position	
TOTAL ASSETS	**2,240,255,898**	TNE	101,486,880
		Funds in Excess of TNE	918,488,109
Deferred Outflows		**TOTAL NET POSITION**	1,019,974,989
Contributions	1,047,297		
Difference in Experience	4,280,308		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,251,916,968**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,251,916,968**

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Board Designated Reserve and TNE Analysis: As of August 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,581,494				
	Tier 1 - MetLife	159,423,340				
	Tier 1 - Wells Capital	159,730,611				
Board-designated Reserve		479,735,445	320,787,669	501,762,475	158,947,777	(22,027,030)
TNE Requirement	Tier 2 - MetLife	107,279,494	101,486,880	101,486,880	5,792,614	5,792,614
	Consolidated:	**587,014,939**	**422,274,549**	**603,249,356**	**164,740,390**	**(16,234,417)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

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Our Mission

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

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UNAUDITED FINANCIAL STATEMENTS

August 31, 2020

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CalOptima - Consolidated
Financial Highlights
For the Two Months Ended August 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
784,741	778,936	5,805	0.7%	Member Months	1,552,486	1,549,448	3,038	0.2%
297,355,487	319,187,852	(21,832,365)	(6.8%)	Revenues	606,061,698	636,045,498	(29,983,800)	(4.7%)
289,485,870	310,483,595	20,997,725	6.8%	Medical Expenses	590,959,455	618,443,697	27,484,242	4.4%
10,238,802	12,698,676	2,459,874	19.4%	Administrative Expenses	22,006,785	25,782,879	3,776,094	14.6%
(2,369,185)	**(3,994,419)**	**1,625,234**	**40.7%**	**Operating Margin**	**(6,904,543)**	**(8,181,078)**	**1,276,535**	**15.6%**
361,648	1,250,000	(888,352)	(71.1%)	Non Operating Income (Loss)	1,748,235	2,500,000	(751,765)	(30.1%)
(2,007,538)	**(2,744,419)**	**736,881**	**26.9%**	**Change in Net Assets**	**(5,156,308)**	**(5,681,078)**	**524,770**	**9.2%**
97.4%	97.3%	(0.1%)		Medical Loss Ratio	97.5%	97.2%	(0.3%)	
3.4%	4.0%	0.5%		Administrative Loss Ratio	3.6%	4.1%	0.4%	
(0.8%)	(1.3%)	0.5%		Operating Margin Ratio	(1.1%)	(1.3%)	0.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

CalOptima
Financial Dashboard
For the Two Months Ended August 31, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	768,296	763,046	5,250	0.7%
OneCare Connect	14,541	14,107	434	3.1%
OneCare	1,523	1,378	145	10.5%
PACE	381	405	(24)	(5.9%)
Total	784,741	778,936	5,805	0.7%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (5,622)	$ (3,177)	$ (2,444)	(77.0%)
OneCare Connect	2,408	(1,055)	3,463	328.2%
OneCare	(88)	45	(134)	(295.6%)
PACE	429	192	236	123.4%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	866	1,250	(384)	(30.7%)
Total	$ (2,007)	$ (2,745)	$ 738	26.9%

MLR

	Actual	Budget	% Point Var
Medi-Cal	98.7%	97.4%	(1.4)
OneCare Connect	86.4%	97.8%	11.5
OneCare	97.2%	89.2%	(8.0)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,501	$ 10,796	$ 2,295	21.3%
OneCare Connect	1,447	1,613	166	10.3%
OneCare	139	137	(2)	(1.8%)
PACE	151	152	1	0.9%
Total	$ 10,239	$ 12,699	$ 2,460	19.4%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,108	1,161	53
OneCare Connect	193	210	16
OneCare	10	9	(1)
PACE	90	116	26
Total	1,402	1,496	94

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	693	657	36
OneCare Connect	75	67	8
OneCare	146	148	(2)
PACE	4	3	1
Total	919	876	43

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	1,519,669	1,517,645	2,024	0.1%
OneCare Connect	29,006	28,241	765	2.7%
OneCare	3,048	2,756	292	10.6%
PACE	763	806	(43)	(5.3%)
Total	1,552,486	1,549,448	3,038	0.2%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (7,392)	$ (6,467)	$ (925)	(14.3%)
OneCare Connect	(1,984)	(2,143)	159	7.4%
OneCare	154	89	64	73.0%
PACE	1,051	340	711	209.1%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	3,016	2,500	516	20.6%
Total	$ (5,155)	$ (5,681)	$ 526	9.3%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.7%	97.3%	(0.4)
OneCare Connect	98.2%	97.8%	(0.3)
OneCare	88.3%	89.2%	0.9

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 18,448	$ 21,933	$ 3,486	15.9%
OneCare Connect	2,959	3,263	303	9.3%
OneCare	300	277	(23)	(8.4%)
PACE	300	311	11	3.4%
Total	$ 22,007	$ 25,783	$ 3,776	14.6%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	2,204	2,322	117
OneCare Connect	388	420	32
OneCare	20	19	(2)
PACE	179	233	54
Total	2,791	2,992	201

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	689	654	36
OneCare Connect	75	67	7
OneCare	151	148	3
PACE	4	3	1
Total	920	873	47

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended August 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	784,741		778,936		5,805	
REVENUE						
Medi-Cal	$ 264,118,627	$ 343.77	$ 288,260,705	$ 377.78	$ (24,142,078)	$ (34.01)
OneCare Connect	28,250,638	1,942.83	25,945,036	1,839.16	2,305,602	103.67
OneCare	1,811,539	1,189.45	1,689,357	1,225.95	122,182	(36.50)
PACE	3,174,683	8,332.50	3,292,754	8,130.26	(118,071)	202.24
Total Operating Revenue	297,355,487	378.92	319,187,852	409.77	(21,832,365)	(30.85)
MEDICAL EXPENSES						
Medi-Cal	260,735,044	339.37	280,641,455	367.79	19,906,411	28.42
OneCare Connect	24,395,259	1,677.69	25,386,789	1,799.59	991,530	121.90
OneCare	1,760,577	1,155.99	1,507,281	1,093.82	(253,296)	(62.17)
PACE	2,594,990	6,811.00	2,948,070	7,279.19	353,080	468.19
Total Medical Expenses	289,485,870	368.89	310,483,595	398.60	20,997,725	29.71
GROSS MARGIN	7,869,617	10.03	8,704,257	11.17	(834,640)	(1.14)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,072,561	9.01	7,943,228	10.20	870,667	1.19
Professional fees	211,589	0.27	369,338	0.47	157,749	0.20
Purchased services	648,777	0.83	1,277,198	1.64	628,421	0.81
Printing & Postage	287,488	0.37	569,733	0.73	282,245	0.36
Depreciation & Amortization	293,692	0.37	460,570	0.59	166,878	0.22
Other expenses	1,346,775	1.72	1,693,025	2.17	346,250	0.45
Indirect cost allocation & Occupancy expense	377,920	0.48	385,584	0.50	7,664	0.02
Total Administrative Expenses	10,238,802	13.05	12,698,676	16.30	2,459,874	3.25
INCOME (LOSS) FROM OPERATIONS	(2,369,185)	(3.02)	(3,994,419)	(5.13)	1,625,234	2.11
INVESTMENT INCOME						
Interest income	1,217,543	1.55	1,250,000	1.60	(32,457)	(0.05)
Realized gain/(loss) on investments	414,933	0.53	-	-	414,933	0.53
Unrealized gain/(loss) on investments	(766,959)	(0.98)	-	-	(766,959)	(0.98)
Total Investment Income	865,517	1.10	1,250,000	1.60	(384,483)	(0.50)
TOTAL MCO TAX	(505,556)	(0.64)	-	-	(505,556)	(0.64)
TOTAL GRANT INCOME	1,575	-	-	-	1,575	-
OTHER INCOME	112	-	-	-	112	-
CHANGE IN NET ASSETS	**(2,007,538)**	**(2.56)**	**(2,744,419)**	**(3.52)**	**736,881**	**0.96**
MEDICAL LOSS RATIO	**97.4%**		**97.3%**		**-0.1%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.0%**		**0.5%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	1,552,486		1,549,448		3,038	
REVENUE						
Medi-Cal	$ 542,952,012	$ 357.28	$ 574,132,985	$ 378.31	$ (31,180,973)	$ (21.03)
OneCare Connect	52,896,867	1,823.65	51,977,029	1,840.48	919,838	(16.83)
OneCare	3,863,114	1,267.43	3,381,473	1,226.95	481,641	40.48
PACE	6,349,704	8,322.02	6,554,011	8,131.53	(204,307)	190.49
Total Operating Revenue	606,061,698	390.38	636,045,498	410.50	(29,983,800)	(20.12)
MEDICAL EXPENSES						
Medi-Cal	530,628,607	349.17	558,666,578	368.11	28,037,971	18.94
OneCare Connect	51,922,089	1,790.05	50,857,910	1,800.85	(1,064,179)	10.80
OneCare	3,409,649	1,118.65	3,015,604	1,094.20	(394,045)	(24.45)
PACE	4,999,109	6,551.91	5,903,605	7,324.57	904,496	772.66
Total Medical Expenses	590,959,455	380.65	618,443,697	399.14	27,484,242	18.49
GROSS MARGIN	15,102,243	9.73	17,601,801	11.36	(2,499,558)	(1.63)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	15,290,055	9.85	16,267,725	10.50	977,670	0.65
Professional fees	523,748	0.34	738,684	0.48	214,936	0.14
Purchased services	1,467,504	0.95	2,554,403	1.65	1,086,899	0.70
Printing & Postage	610,174	0.39	1,139,468	0.74	529,294	0.35
Depreciation & Amortization	590,627	0.38	921,140	0.59	330,513	0.21
Other expenses	2,783,059	1.79	3,389,686	2.19	606,628	0.40
Indirect cost allocation & Occupancy expense	741,620	0.48	771,773	0.50	30,153	0.02
Total Administrative Expenses	22,006,785	14.18	25,782,879	16.64	3,776,094	2.46
INCOME (LOSS) FROM OPERATIONS	(6,904,543)	(4.45)	(8,181,078)	(5.28)	1,276,535	0.83
INVESTMENT INCOME						
Interest income	2,547,059	1.64	2,500,000	1.61	47,059	0.03
Realized gain/(loss) on investments	1,661,801	1.07	-	-	1,661,801	1.07
Unrealized gain/(loss) on investments	(1,192,682)	(0.77)	-	-	(1,192,682)	(0.77)
Total Investment Income	3,016,178	1.94	2,500,000	1.61	516,178	0.33
TOTAL MCO TAX	(1,274,993)	(0.82)	-	-	(1,274,993)	(0.82)
TOTAL GRANT INCOME	6,862	-	-	-	6,862	-
OTHER INCOME	187	-	-	-	187	-
CHANGE IN NET ASSETS	**(5,156,308)**	**(3.32)**	**(5,681,078)**	**(3.67)**	**524,770**	**0.35**
MEDICAL LOSS RATIO	**97.5%**		**97.2%**		**-0.3%**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**4.1%**		**0.4%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended August 31, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	508,307	250,724	9,265	768,296	14,541	1,523	381	784,741
REVENUES								
Capitation Revenue	154,637,413	$ 91,400,719	$ 18,080,495	$ 264,118,627	$ 28,250,638	$ 1,811,539	$ 3,174,683	$ 297,355,487
Total Operating Revenue	154,637,413	91,400,719	18,080,495	264,118,627	28,250,638	1,811,539	3,174,683	297,355,487
MEDICAL EXPENSES								
Provider Capitation	33,755,576	43,015,882	10,874,615	87,646,073	10,877,619	479,386		99,003,079
Facilities	22,641,481	20,414,401	2,182,940	45,238,822	3,963,859	487,678	866,545	50,556,904
Professional Claims	18,523,166	8,564,308	1,015,499	28,102,973	820,577	58,419	590,431	29,572,399
Prescription Drugs	20,143,633	24,459,693	3,921,905	48,525,231	6,099,932	681,919	261,489	55,568,571
MLTSS	39,619,953	3,189,045	2,939,547	45,748,545	1,307,600	15,139	2,934	47,074,218
Medical Management	2,124,382	1,243,395	274,468	3,642,245	990,339	38,035	759,740	5,430,360
Quality Incentives	786,971	464,672	31,179	1,282,822	215,505		4,763	1,503,089
Reinsurance & Other	352,996	184,682	10,655	548,333	119,829		109,088	777,250
Total Medical Expenses	137,948,158	101,536,078	21,250,808	260,735,044	24,395,259	1,760,577	2,594,990	289,485,870
Medical Loss Ratio	89.2%	111.1%	117.5%	98.7%	86.4%	97.2%	81.7%	97.4%
GROSS MARGIN	**16,689,255**	**(10,135,360)**	**(3,170,313)**	**3,383,583**	**3,855,379**	**50,962**	**579,694**	**7,869,617**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,147,488	710,932	74,231	139,910	7,072,561
Professional fees				190,132	5,334	16,000	123	211,589
Purchased services				566,305	73,474	8,561	438	648,777
Printing & Postage				214,189	67,715	5,274	310	287,488
Depreciation & Amortization				291,674			2,018	293,692
Other expenses				1,306,426	36,028	205	4,116	1,346,775
Indirect cost allocation & Occupancy				(214,879)	553,492	35,185	4,122	377,920
Total Administrative Expenses				8,501,334	1,446,975	139,456	151,037	10,238,802
Admin Loss Ratio				3.2%	5.1%	7.7%	4.8%	3.4%
INCOME (LOSS) FROM OPERATIONS				(5,117,752)	2,408,404	(88,494)	428,656	(2,369,185)
INVESTMENT INCOME								865,517
TOTAL MCO TAX				(505,556)				(505,556)
TOTAL GRANT INCOME				1,575				1,575
OTHER INCOME				112				112
CHANGE IN NET ASSETS				**$ (5,621,621)**	**$ 2,408,404**	**$ (88,494)**	**$ 428,656**	**$ (2,007,538)**
BUDGETED CHANGE IN NET ASSETS				(3,177,210)	(1,054,587)	45,116	192,262	(2,744,419)
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,444,411)	$ 3,462,991	$ (133,610)	$ 236,394	$ 736,881

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ended August 31, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,006,447	494,883	18,339	1,519,669	29,006	3,048	763	1,552,486
REVENUES								
Capitation Revenue	302,323,119	$ 204,597,932	$ 36,030,961	$ 542,952,012	$ 52,896,867	$ 3,863,114	$ 6,349,704	$ 606,061,698
Total Operating Revenue	302,323,119	204,597,932	36,030,961	542,952,012	52,896,867	3,863,114	6,349,704	606,061,698
MEDICAL EXPENSES								
Provider Capitation	71,415,436	84,710,230	21,954,010	178,079,676	22,149,663	1,036,304		201,265,644
Facilities	48,043,050	44,867,777	6,271,680	99,182,507	8,934,562	916,161	1,512,517	110,545,746
Professional Claims	38,735,660	18,320,249	2,366,803	59,422,711	1,888,469	154,170	1,111,897	62,577,247
Prescription Drugs	41,603,533	49,531,187	6,247,363	97,382,083	12,955,347	1,162,724	533,063	112,033,218
MLTSS	74,501,838	6,008,092	4,385,483	84,895,413	3,154,204	66,834	89	88,116,540
Medical Management	4,732,515	2,706,732	583,802	8,023,049	2,155,884	73,456	1,596,460	11,848,849
Quality Incentives	1,564,435	919,346	62,721	2,546,501	427,920		9,538	2,983,959
Reinsurance & Other	706,961	368,039	21,666	1,096,667	256,040		235,546	1,588,253
Total Medical Expenses	281,303,428	207,431,652	41,893,528	530,628,607	51,922,089	3,409,649	4,999,109	590,959,455
Medical Loss Ratio	93.0%	101.4%	116.3%	97.7%	98.2%	88.3%	78.7%	97.5%
GROSS MARGIN	**21,019,691**	**(2,833,719)**	**(5,862,567)**	**12,323,405**	**974,778**	**453,465**	**1,350,595**	**15,102,243**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				13,374,453	1,464,705	176,515	274,383	15,290,055
Professional fees				480,918	10,667	32,000	163	523,748
Purchased services				1,288,170	166,905	9,387	3,041	1,467,504
Printing & Postage				462,845	131,330	11,427	4,572	610,174
Depreciation & Amortization				586,519			4,107	590,627
Other expenses				2,698,760	78,572	205	5,521	2,783,059
Indirect cost allocation & Occupancy				(443,954)	1,106,984	70,370	8,220	741,620
Total Administrative Expenses				18,447,712	2,959,162	299,904	300,007	22,006,785
Admin Loss Ratio				3.4%	5.6%	7.8%	4.7%	3.6%
INCOME (LOSS) FROM OPERATIONS				(6,124,307)	(1,984,384)	153,561	1,050,587	(6,904,543)
INVESTMENT INCOME								3,016,178
TOTAL MCO TAX				(1,274,993)				(1,274,993)
TOTAL GRANT INCOME				6,862				6,862
OTHER INCOME				187				187
CHANGE IN NET ASSETS				**$ (7,392,250)**	**$ (1,984,384)**	**$ 153,561**	**$ 1,050,587**	**$ (5,156,308)**
BUDGETED CHANGE IN NET ASSETS				(6,466,805)	(2,143,450)	89,324	339,853	(5,681,078)
VARIANCE TO BUDGET - FAV (UNFAV)				$ (925,445)	$ 159,066	$ 64,237	$ 710,734	$ 524,770

August 31, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is ($2.0) million, $0.7 million favorable to budget
- Operating deficit is $2.4 million, with a surplus in non-operating income of $0.4 million

YEAR TO DATE RESULTS:

- Change in Net Assets is ($5.2) million, $0.5 million favorable to budget
- Operating deficit is ($6.9) million, with a surplus in non-operating income of $1.7 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(5.1)	(3.2)	(1.9)	Medi-Cal	(6.1)	(6.5)	0.3
2.4	(1.1)	3.5	OCC	(2.0)	(2.1)	0.2
(0.1)	0.0	(0.1)	OneCare	0.2	0.1	0.1
0.4	0.2	0.2	PACE	1.1	0.3	0.7
(2.4)	**(4.0)**	**1.6**	**Operating**	**(6.9)**	**(8.2)**	**1.3**
0.4	1.3	(0.9)	Inv./Rental Inc, MCO tax	1.7	2.5	(0.8)
0.4	**1.3**	**(0.9)**	**Non-Operating**	**1.7**	**2.5**	**(0.8)**
(2.0)	**(2.7)**	**0.7**	**TOTAL**	**(5.2)**	**(5.7)**	**0.5**

CalOptima - Consolidated
Enrollment Summary
For the Two Months Ended August 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
113,120	110,815	2,305	2.1%	SPD	225,510	221,592	3,918	1.8%
510	489	21	4.3%	BCCTP	1,020	982	38	3.9%
291,791	301,672	(9,881)	(3.3%)	TANF Child	580,029	599,025	(18,996)	(3.2%)
96,712	90,771	5,941	6.5%	TANF Adult	190,284	180,281	10,003	5.5%
6,174	3,507	2,667	76.0%	LTC	9,604	7,012	2,592	37.0%
250,724	243,860	6,864	2.8%	MCE	494,883	484,889	9,994	2.1%
9,265	11,932	(2,667)	(22.4%)	WCM	18,339	23,864	(5,525)	(23.2%)
768,296	**763,046**	**5,250**	**0.7%**	**Medi-Cal Total**	**1,519,669**	**1,517,645**	**2,024**	**0.1%**
14,541	**14,107**	**434**	**3.1%**	**OneCare Connect**	**29,006**	**28,241**	**765**	**2.7%**
1,523	**1,378**	**145**	**10.5%**	**OneCare**	**3,048**	**2,756**	**292**	**10.6%**
381	**405**	**(24)**	**(5.9%)**	**PACE**	**763**	**806**	**(43)**	**(5.3%)**
784,741	**778,936**	**5,805**	**0.7%**	**CalOptima Total**	**1,552,486**	**1,549,448**	**3,038**	**0.2%**
				Enrollment (by Network)				
173,442	170,357	3,085	1.8%	HMO	343,817	338,928	4,889	1.4%
216,895	219,928	(3,033)	(1.4%)	PHC	430,978	437,238	(6,260)	(1.4%)
184,919	185,863	(944)	(0.5%)	Shared Risk Group	366,058	368,865	(2,807)	(0.8%)
193,040	186,898	6,142	3.3%	Fee for Service	378,816	372,614	6,202	1.7%
768,296	**763,046**	**5,250**	**0.7%**	**Medi-Cal Total**	**1,519,669**	**1,517,645**	**2,024**	**0.1%**
14,541	**14,107**	**434**	**3.1%**	**OneCare Connect**	**29,006**	**28,241**	**765**	**2.7%**
1,523	**1,378**	**145**	**10.5%**	**OneCare**	**3,048**	**2,756**	**292**	**10.6%**
381	**405**	**(24)**	**(5.9%)**	**PACE**	**763**	**806**	**(43)**	**(5.3%)**
784,741	**778,936**	**5,805**	**0.7%**	**CalOptima Total**	**1,552,486**	**1,549,448**	**3,038**	**0.2%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,536	10,583											21,119	20,713	406
BCCTP	1	1											2	2	0
TANF Child	54,644	55,088											109,732	113,140	(3,408)
TANF Adult	29,033	29,687											58,720	56,927	1,793
LTC	(1)	402											401	4	397
MCE	74,441	75,955											150,396	144,052	6,344
WCM	1,721	1,726											3,447	4,090	(643)
Total	**170,375**	**173,442**											**343,817**	**338,928**	**4,889**
PHCs															
SPD	7,145	7,205											14,350	14,045	305
BCCTP													-		0
TANF Child	149,810	151,008											300,818	309,733	(8,915)
TANF Adult	11,688	12,097											23,785	22,139	1,646
LTC		158											158	2	156
MCE	39,815	40,711											80,526	76,953	3,573
WCM	5,625	5,716											11,341	14,366	(3,025)
Total	**214,083**	**216,895**											**430,978**	**437,238**	**(6,260)**
Shared Risk Groups															
SPD	10,264	10,312											20,576	20,380	196
BCCTP													-		0
TANF Child	58,289	58,687											116,976	124,223	(7,247)
TANF Adult	28,914	29,648											58,562	57,010	1,552
LTC	1	365											366	4	362
MCE	82,747	84,907											167,654	163,862	3,792
WCM	924	1,000											1,924	3,386	(1,462)
Total	**181,139**	**184,919**											**366,058**	**368,865**	**(2,807)**
Fee for Service (Dual)															
SPD	74,615	75,198											149,813	146,798	3,015
BCCTP	12	17											29	34	(5)
TANF Child	1	1											2	4	(2)
TANF Adult	909	1,266											2,175	1,911	264
LTC	3,079	4,461											7,540	6,316	1,224
MCE	1,658	1,859											3,517	2,669	848
WCM	13	17											30	26	4
Total	**80,287**	**82,819**											**163,106**	**157,758**	**5,348**
Fee for Service (Non-Dual - Total)															
SPD	9,830	9,822											19,652	19,656	(4)
BCCTP	497	492											989	946	43
TANF Child	25,494	27,007											52,501	51,925	576
TANF Adult	23,028	24,014											47,042	42,294	4,748
LTC	351	788											1,139	686	453
MCE	45,498	47,292											92,790	97,353	(4,563)
WCM	791	806											1,597	1,996	(399)
Total	**105,489**	**110,221**											**215,710**	**214,856**	**854**
SPD	112,390	113,120											225,510	221,592	3,918
BCCTP	510	510											1,020	982	38
TANF Child	288,238	291,791											580,029	599,025	(18,996)
TANF Adult	93,572	96,712											190,284	180,281	10,003
LTC	3,430	6,174											9,604	7,012	2,592
MCE	244,159	250,724											494,883	484,889	9,994
WCM	9,074	9,265											18,339	23,864	(5,525)
Total Medi-Cal MM	**751,373**	**768,296**											**1,519,669**	**1,517,645**	**2,024**
OneCare Connect	**14,465**	**14,541**											**29,006**	**28,241**	**765**
OneCare	**1,525**	**1,523**											**3,048**	**2,756**	**292**
PACE	**382**	**381**											**763**	**806**	**(43)**
Grand Total	**767,745**	**784,741**											**1,552,486**	**1,549,448**	**3,038**

ENROLLMENT:

Overall, August enrollment was 784,741

- Favorable to budget 5,805 or 0.7%
- Increased 16,996 or 2.2% from prior month (PM) (July 2020)
- Increased 22,709 or 3.0% from prior year (PY) (August 2019)

Medi-Cal enrollment was 768,296

- Favorable to budget 5,250 or 0.7% due to prior year retroactive enrollment
  - Medi-Cal Expansion (MCE) favorable 6,864
  - Long-Term Care (LTC) favorable 2,667
  - Seniors and Persons with Disabilities (SPD) favorable 2,305
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 21
  - Temporary Assistance for Needy Families (TANF) unfavorable 3,940
  - Whole Child Model (WCM) unfavorable 2,667
- Increased 16,923 from PM, 4,015 due to prior year retroactive enrollment

OneCare Connect enrollment was 14,541

- Favorable to budget 434 or 3.1%
- Increased 76 from PM

OneCare enrollment was 1,523

- Favorable to budget 145 or 10.5%
- Decreased 2 from PM

PACE enrollment was 381

- Unfavorable to budget 24 or 5.9%
- Decreased 1 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
768,296	**763,046**	**5,250**	**0.7%**	**Member Months**	**1,519,669**	**1,517,645**	**2,024**	**0.1%**
				Revenues				
264,118,627	288,260,705	(24,142,078)	(8.4%)	Capitation Revenue	542,952,012	574,132,985	(31,180,973)	(5.4%)
-	-	-	0.0%	Other Income	-	-	-	0.0%
264,118,627	**288,260,705**	**(24,142,078)**	**(8.4%)**	**Total Operating Revenue**	**542,952,012**	**574,132,985**	**(31,180,973)**	**(5.4%)**
				Medical Expenses				
88,928,895	97,085,701	8,156,806	8.4%	Provider Capitation	180,626,178	193,072,175	12,445,997	6.4%
45,238,822	57,937,417	12,698,595	21.9%	Facilities Claims	99,182,507	115,238,133	16,055,626	13.9%
28,102,973	32,837,598	4,734,625	14.4%	Professional Claims	59,422,711	65,361,869	5,939,158	9.1%
48,525,231	46,724,423	(1,800,808)	(3.9%)	Prescription Drugs	97,382,083	92,872,759	(4,509,324)	(4.9%)
45,748,545	40,650,161	(5,098,384)	(12.5%)	MLTSS	84,895,413	81,191,707	(3,703,706)	(4.6%)
3,642,245	4,802,149	1,159,904	24.2%	Medical Management	8,023,049	9,721,923	1,698,874	17.5%
548,333	604,006	55,673	9.2%	Reinsurance & Other	1,096,667	1,208,012	111,345	9.2%
260,735,044	**280,641,455**	**19,906,411**	**7.1%**	**Total Medical Expenses**	**530,628,607**	**558,666,578**	**28,037,971**	**5.0%**
3,383,583	**7,619,250**	**(4,235,667)**	**(55.6%)**	**Gross Margin**	**12,323,405**	**15,466,407**	**(3,143,002)**	**(20.3%)**
				Administrative Expenses				
6,147,488	6,969,595	822,107	11.8%	Salaries, Wages & Employee Benefits	13,374,453	14,276,267	901,814	6.3%
190,132	313,089	122,957	39.3%	Professional Fees	480,918	626,186	145,268	23.2%
566,305	1,146,260	579,955	50.6%	Purchased Services	1,288,170	2,292,527	1,004,357	43.8%
214,189	443,433	229,244	51.7%	Printing and Postage	462,845	886,866	424,021	47.8%
291,674	458,500	166,826	36.4%	Depreciation & Amortization	586,519	917,000	330,481	36.0%
1,306,426	1,673,096	366,670	21.9%	Other Operating Expenses	2,698,760	3,348,762	650,002	19.4%
(214,879)	(207,513)	7,366	3.5%	Indirect Cost Allocation, Occupancy Expense	(443,954)	(414,396)	29,558	7.1%
8,501,334	**10,796,460**	**2,295,126**	**21.3%**	**Total Administrative Expenses**	**18,447,712**	**21,933,212**	**3,485,500**	**15.9%**
				Operating Tax				
11,963,194	14,778,816	(2,815,622)	(19.1%)	Tax Revenue	23,662,508	29,396,541	(5,734,034)	(19.5%)
12,468,750	14,778,816	2,310,066	15.6%	Premium Tax Expense	24,937,500	29,396,541	4,459,041	15.2%
(505,556)	-	(505,556)	**0.0%**	**Total Net Operating Tax**	(1,274,993)	-	(1,274,993)	**0.0%**
				Grant Income				
15,831	-	15,831	0.0%	Grant Revenue	51,081	-	51,081	0.0%
8,925	-	(8,925)	0.0%	Grant expense - Service Partner	38,888	-	(38,888)	0.0%
5,331	-	(5,331)	0.0%	Grant expense - Administrative	5,331	-	(5,331)	0.0%
1,575	-	1,575	**0.0%**	**Total Grant Income**	6,863	-	6,863	**0.0%**
112	**-**	**112**	**0.0%**	**Other income**	**187**	**-**	**187**	**0.0%**
(5,621,621)	**(3,177,210)**	**(2,444,411)**	**(76.9%)**	**Change in Net Assets**	**(7,392,250)**	**(6,466,805)**	**(925,445)**	**(14.3%)**
98.7%	***97.4%***	***(1.4%)***	***(1.4%)***	***Medical Loss Ratio***	***97.7%***	***97.3%***	***(0.4%)***	***(0.4%)***
3.2%	***3.7%***	***0.5%***	***14.1%***	***Admin Loss Ratio***	***3.4%***	***3.8%***	***0.4%***	***11.1%***

MEDI-CAL INCOME STATEMENT – AUGUST MONTH:

REVENUES of $264.1 million are unfavorable to budget $24.1 million driven by:

- Favorable volume related variance of $2.0 million
- Unfavorable price related variance of $26.1 million
  - $37.8 million of revenue due to Governor's budget changes for the eighteen (18)-months bridge period, including:
    - Gross Medical Expenditures (GME) risk corridor reserve
    - 1.5% reduction to fiscal year (FY) 2021 capitation rates for certain aid code categories
  - $5.6 million of WCM revenue
  - $2.9 million of Behavioral Health Treatment (BHT) revenue
  - Offset by $22.7 million of Coordinated Care Initiative (CCI) revenue due to new calendar year (CY) 2020 rate true-up in August

MEDICAL EXPENSES of $260.7 million are favorable to budget $19.9 million driven by:

- Unfavorable volume related variance of $1.9 million
- Favorable price related variance of $21.8 million primarily due to decrease in utilization during COVID-19 pandemic
  - Facilities Claims expense favorable variance of $13.1 million
  - Provider Capitation expense favorable variance of $8.8 million
  - Professional Claims expense favorable variance of $5.0 million
  - Medical Management expense favorable variance of $1.2 million
  - Offset by Managed Long Term Services and Supports (MLTSS) expense unfavorable variance of $4.8 million due to the 10% reimbursement rate increase and Prescription Drugs expense unfavorable variance of $1.5 million

ADMINISTRATIVE EXPENSES of $8.5 million are favorable to budget $2.3 million driven by:

- Salaries & Benefit expense favorable to budget $0.8 million
- Other Non-Salary expense favorable to budget $1.5 million

CHANGE IN NET ASSETS is ($5.6) million for the month, unfavorable to budget $2.4 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Two Months Ending August 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,541	**14,107**	**434**	**3.1%**	**Member Months**	**29,006**	**28,241**	**765**	**2.7%**
				Revenues				
4,731,785	2,723,591	2,008,194	73.7%	Medi-Cal Capitation Revenue	6,829,092	5,452,400	1,376,692	25.2%
17,498,193	17,989,536	(491,343)	(2.7%)	Medicare Capitation Revenue Part C	35,469,546	36,050,035	(580,489)	(1.6%)
6,020,660	5,231,909	788,751	15.1%	Medicare Capitation Revenue Part D	10,598,229	10,474,594	123,635	1.2%
-	-	-	0.0%	Other Income	-	-	-	0.0%
28,250,638	**25,945,036**	**2,305,602**	**8.9%**	**Total Operating Revenue**	**52,896,867**	**51,977,029**	**919,838**	**1.8%**
				Medical Expenses				
11,093,124	11,482,832	389,708	3.4%	Provider Capitation	22,577,583	23,022,705	445,122	1.9%
3,963,859	4,040,815	76,956	1.9%	Facilities Claims	8,934,562	8,070,049	(864,513)	(10.7%)
820,577	944,642	124,065	13.1%	Ancillary	1,888,469	1,885,077	(3,392)	(0.2%)
1,307,600	1,569,085	261,485	16.7%	MLTSS	3,154,204	3,144,098	(10,106)	(0.3%)
6,099,932	5,937,607	(162,325)	(2.7%)	Prescription Drugs	12,955,347	11,859,033	(1,096,314)	(9.2%)
990,339	1,194,773	204,434	17.1%	Medical Management	2,155,884	2,444,520	288,636	11.8%
119,829	217,035	97,206	44.8%	Other Medical Expenses	256,040	432,428	176,388	40.8%
24,395,259	**25,386,789**	**991,530**	**3.9%**	**Total Medical Expenses**	**51,922,089**	**50,857,910**	**(1,064,179)**	**(2.1%)**
3,855,379	**558,247**	**3,297,132**	**590.6%**	**Gross Margin**	**974,778**	**1,119,119**	**(144,341)**	**(12.9%)**
				Administrative Expenses				
710,932	793,476	82,544	10.4%	Salaries, Wages & Employee Benefits	1,464,705	1,622,845	158,140	9.7%
5,334	40,083	34,749	86.7%	Professional Fees	10,667	80,166	69,499	86.7%
73,474	103,412	29,938	29.0%	Purchased Services	166,905	206,824	39,919	19.3%
67,715	106,516	38,801	36.4%	Printing and Postage	131,330	213,034	81,704	38.4%
36,028	15,855	(20,173)	(127.2%)	Other Operating Expenses	78,572	32,716	(45,856)	(140.2%)
553,492	553,492	-	0.0%	Indirect Cost Allocation	1,106,984	1,106,984	-	0.0%
1,446,975	**1,612,834**	**165,859**	**10.3%**	**Total Administrative Expenses**	**2,959,162**	**3,262,569**	**303,407**	**9.3%**
2,408,404	**(1,054,587)**	**3,462,991**	**328.4%**	**Change in Net Assets**	**(1,984,384)**	**(2,143,450)**	**159,066**	**7.4%**
86.4%	***97.8%***	***11.5%***	***11.7%***	***Medical Loss Ratio***	***98.2%***	***97.8%***	***(0.3%)***	***(0.3%)***
5.1%	***6.2%***	***1.1%***	***17.6%***	***Admin Loss Ratio***	***5.6%***	***6.3%***	***0.7%***	***10.9%***

ONECARE CONNECT INCOME STATEMENT– AUGUST MONTH:

REVENUES of $28.3 million are favorable to budget $2.3 million driven by:

- Favorable volume related variance of $0.8 million
- Favorable price related variance of $1.5 million due to CY 2020 rate true-up revenue

MEDICAL EXPENSES of $24.4 million are favorable to budget $1.0 million driven by:

- Unfavorable volume related variance of $0.8 million
- Favorable price related variance of $1.8 million
  - Provider Capitation expense favorable variance of $0.7 million
  - MLTSS expense favorable variance of $0.3 million
  - Medical Management expense favorable variance of $0.2 million
  - Facilities Claims expense favorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $1.4 million are favorable to budget $0.2 million

CHANGE IN NET ASSETS is $2.4 million, favorable to budget $3.5 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,523	**1,378**	**145**	**10.5%**	**Member Months**	**3,048**	**2,756**	**292**	**10.6%**
				Revenues				
1,227,035	1,152,171	74,864	6.5%	Medicare Part C revenue	2,637,056	2,307,051	330,005	14.3%
584,503	537,186	47,317	8.8%	Medicare Part D revenue	1,226,058	1,074,422	151,636	14.1%
1,811,539	**1,689,357**	**122,182**	**7.2%**	**Total Operating Revenue**	**3,863,114**	**3,381,473**	**481,641**	**14.2%**
				Medical Expenses				
479,386	446,134	(33,252)	(7.5%)	Provider Capitation	1,036,304	893,314	(142,990)	(16.0%)
487,678	457,868	(29,810)	(6.5%)	Inpatient	916,161	916,359	198	0.0%
58,419	43,175	(15,244)	(35.3%)	Ancillary	154,170	86,247	(67,923)	(78.8%)
15,139	25,895	10,756	41.5%	Skilled Nursing Facilities	66,834	51,790	(15,044)	(29.0%)
681,919	490,537	(191,382)	(39.0%)	Prescription Drugs	1,162,724	979,139	(183,585)	(18.7%)
38,035	43,672	5,637	12.9%	Medical Management	73,456	88,755	15,299	17.2%
1,760,577	**1,507,281**	**(253,296)**	**(16.8%)**	**Total Medical Expenses**	**3,409,649**	**3,015,604**	**(394,045)**	**(13.1%)**
50,962	**182,076**	**(131,114)**	**(72.0%)**	**Gross Margin**	**453,465**	**365,869**	**87,596**	**23.9%**
				Administrative Expenses				
74,231	67,404	(6,827)	(10.1%)	Salaries, wages & employee benefits	176,515	137,433	(39,082)	(28.4%)
16,000	16,000	-	0.0%	Professional fees	32,000	32,000	-	0.0%
8,561	9,750	1,189	12.2%	Purchased services	9,387	19,500	10,113	51.9%
5,274	8,084	2,810	34.8%	Printing and postage	11,427	16,168	4,741	29.3%
205	537	332	61.8%	Other operating expenses	205	1,074	869	80.9%
35,185	35,185	-	0.0%	Indirect cost allocation, occupancy expense	70,370	70,370	-	0.0%
139,456	**136,960**	**(2,496)**	**(1.8%)**	**Total Administrative Expenses**	**299,904**	**276,545**	**(23,359)**	**(8.4%)**
(88,494)	**45,116**	**(133,610)**	**(296.1%)**	**Change in Net Assets**	**153,561**	**89,324**	**64,237**	**71.9%**
97.2%	***89.2%***	***(8.0%)***	***(8.9%)***	***Medical Loss Ratio***	***88.3%***	***89.2%***	***0.9%***	***1.0%***
7.7%	***8.1%***	***0.4%***	***5.0%***	***Admin Loss Ratio***	***7.8%***	***8.2%***	***0.4%***	***5.1%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
381	**405**	**(24)**	**(5.9%)**	**Member Months**	**763**	**806**	**(43)**	**-5.3%**
				Revenues				
2,402,406	2,549,557	(147,151)	(5.8%)	Medi-Cal Capitation Revenue	4,802,600	5,074,168	(271,568)	(5.4%)
634,148	599,035	35,113	5.9%	Medicare Part C Revenue	1,286,233	1,192,998	93,235	7.8%
138,130	144,162	(6,032)	(4.2%)	Medicare Part D Revenue	260,870	286,845	(25,975)	(9.1%)
3,174,683	**3,292,754**	**(118,071)**	**(3.6%)**	**Total Operating Revenue**	**6,349,704**	**6,554,011**	**(204,307)**	**(3.1%)**
				Medical Expenses				
759,740	937,279	177,539	18.9%	Medical Management	1,596,460	1,911,446	314,986	16.5%
866,545	772,080	(94,465)	(12.2%)	Facilities Claims	1,512,517	1,531,029	18,512	1.2%
590,431	645,817	55,386	8.6%	Professional Claims	1,111,897	1,284,283	172,386	13.4%
109,088	246,536	137,448	55.8%	Patient Transportation	235,546	489,479	253,933	51.9%
261,489	268,352	6,863	2.6%	Prescription Drugs	533,063	533,358	295	0.1%
2,934	59,788	56,854	95.1%	MLTSS	89	117,753	117,664	99.9%
4,763	18,218	13,456	73.9%	Other Expenses	9,538	36,257	26,720	73.7%
2,594,990	**2,948,070**	**353,080**	**12.0%**	**Total Medical Expenses**	**4,999,109**	**5,903,605**	**904,496**	**15.3%**
579,694	**344,684**	**235,010**	**68.2%**	**Gross Margin**	**1,350,595**	**650,406**	**700,189**	**107.7%**
				Administrative Expenses				
139,910	112,753	(27,157)	(24.1%)	Salaries, wages & employee benefits	274,383	231,180	(43,203)	(18.7%)
123	166	43	25.7%	Professional fees	163	332	169	50.8%
438	17,776	17,338	97.5%	Purchased services	3,041	35,552	32,511	91.4%
310	11,700	11,390	97.3%	Printing and postage	4,572	23,400	18,828	80.5%
2,018	2,070	52	2.5%	Depreciation & amortization	4,107	4,140	33	0.8%
4,116	3,537	(579)	(16.4%)	Other operating expenses	5,521	7,134	1,613	22.6%
4,122	4,420	298	6.7%	Indirect Cost Allocation, Occupancy Expense	8,220	8,815	595	6.8%
151,037	**152,422**	**1,385**	**0.9%**	**Total Administrative Expenses**	**300,007**	**310,553**	**10,546**	**3.4%**
				Operating Tax				
5,654	-	5,654	0.0%	Tax Revenue	11,323	-	11,323	0.0%
5,654	-	(5,654)	0.0%	Premium Tax Expense	11,323	-	(11,323)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
428,656	**192,262**	**236,394**	**123.0%**	**Change in Net Assets**	**1,050,587**	**339,853**	**710,734**	**209.1%**
81.7%	***89.5%***	***7.8%***	***8.7%***	***Medical Loss Ratio***	***78.7%***	***90.1%***	***11.3%***	***12.6%***
4.8%	***4.6%***	***(0.1%)***	***(2.8%)***	***Admin Loss Ratio***	***4.7%***	***4.7%***	***0.0%***	***0.3%***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
44,181	55,000	10,819	19.7%	Purchase services	88,773	110,000	21,227	19.3%
170,912	177,250	6,338	3.6%	Depreciation & amortization	341,824	354,500	12,676	3.6%
18,423	18,500	77	0.4%	Insurance expense	36,845	37,000	155	0.4%
100,241	114,917	14,676	12.8%	Repair and maintenance	197,954	229,834	31,880	13.9%
71,749	41,250	(30,499)	(73.9%)	Other Operating Expense	128,411	82,500	(45,911)	(55.6%)
(405,505)	(406,917)	(1,412)	(0.3%)	Indirect allocation, Occupancy	(793,807)	(813,834)	(20,027)	(2.5%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

OTHER INCOME STATEMENTS – AUGUST MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($0.1) million, unfavorable to budget $0.1 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.4 million, favorable to budget $0.2 million

CalOptima
Balance Sheet
August 31, 2020

ASSETS			**LIABILITIES & NET POSITION**		
Current Assets			Current Liabilities		
	Operating Cash	$361,974,043		Accounts Payable	$98,432,577
	Investments	785,112,848		Medical Claims liability	893,811,200
	Capitation receivable	347,726,085		Accrued Payroll Liabilities	15,949,699
	Receivables - Other	46,737,741		Deferred Revenue	22,338,791
	Prepaid expenses	6,927,548		Deferred Lease Obligations	160,858
				Capitation and Withholds	142,027,078
	Total Current Assets	**1,548,478,265**		**Total Current Liabilities**	**1,172,720,202**
Capital Assets					
	Furniture & Equipment	39,890,502			
	Building/Leasehold Improvements	10,077,966			
	505 City Parkway West	51,620,226			
		101,588,694			
	Less: accumulated depreciation	(54,324,913)			
	Capital assets, net	47,263,780	Other (than pensions) post		
				employment benefits liability	25,899,469
Other Assets			Net Pension Liabilities		26,645,035
	Restricted Deposit & Other	300,000	Bldg 505 Development Rights		-
	Homeless Health Reserve	57,198,913			
	Board-designated assets:			**TOTAL LIABILITIES**	**1,225,264,706**
	Cash and Cash Equivalents	3,104,429			
	Long-term Investments	583,910,510	Deferred Inflows		
	Total Board-designated Assets	587,014,939		Excess Earnings	506,547
				OPEB 75 Difference in Experience	804,000
				Change in Assumptions	3,728,725
	Total Other Assets	644,513,852		OPEB Changes in Assumptions	1,638,000
			Net Position		
TOTAL ASSETS		**2,240,255,898**		TNE	101,486,880
				Funds in Excess of TNE	918,488,109
Deferred Outflows			**TOTAL NET POSITION**		1,019,974,989
	Contributions	1,047,297			
	Difference in Experience	4,280,308			
	Changes in Assumptions	5,060,465			
	OPEB 75 Changes in Assumptions	703,000			
	Pension Contributions	570,000			
	TOTAL ASSETS & DEFERRED OUTFLOWS	**2,251,916,968**		**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,251,916,968**

CalOptima
Board Designated Reserve and TNE Analysis
as of August 31, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,581,494				
	Tier 1 - MetLife	159,423,340				
	Tier 1 - Wells Capital	159,730,611				
Board-designated Reserve		479,735,445	320,787,669	501,762,475	158,947,777	(22,027,030)
TNE Requirement	Tier 2 - MetLife	107,279,494	101,486,880	101,486,880	5,792,614	5,792,614
	Consolidated:	**587,014,939**	**422,274,549**	**603,249,356**	**164,740,390**	**(16,234,417)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
August 31, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(2,007,538)	(5,156,308)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	464,604	932,450
Changes in assets and liabilities:		
Prepaid expenses and other	238,816	(228,340)
Catastrophic reserves		
Capitation receivable	(24,437,970)	51,906,199
Medical claims liability	36,873,148	(23,340,820)
Deferred revenue	(24,909,872)	(1,084,905)
Payable to health networks	513,746	(953,950)
Accounts payable	12,388,195	23,776,131
Accrued payroll	(85,404)	1,925,452
Other accrued liabilities	-	-
Net cash provided by/(used in) operating activities	(962,274)	47,775,910
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(94,651,809)	(195,646,746)
Change in Property and Equipment	(250,466)	(1,541,660)
Change in Board designated reserves	(536,145)	(2,131,046)
Net cash provided by/(used in) investing activities	(95,438,420)	(199,319,451)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(96,400,694)	(151,543,541)
CASH AND CASH EQUIVALENTS, beginning of period	$458,374,737	513,517,584
CASH AND CASH EQUIVALENTS, end of period	**361,974,043**	**361,974,043**

BALANCE SHEET – AUGUST MONTH:

ASSETS of $2.3 billion increased $22.8 million from July or 1.0%

- Operating Cash decreased $96.4 million due to the timing of cash receipts and disbursements
- Investments increased $94.7 million due to the timing of cash receipts and month-end requirements for operating cash.
- Capitation Receivables increased $22.1 million due to CCI rate increase for CY 2020.
- Receivables – Other increased $2.3 million due to Centers for Medicare & Medicaid Services (CMS) estimated prescription drug receivables

LIABILITIES of $1.2 billion increased $24.8 million from July or 2.1%

- Claims Liabilities increased $36.9 million due to timing of claim payment and change in Incurred But Not Reported (IBNR)
- Deferred Revenue decreased $24.9 million due to timing of capitation payments from CMS
- Accounts Payable increased $12.4 million due to the payment timing of Managed Care Organization (MCO) tax

NET ASSETS of $1.0 billion, decreased $2.0 million from July or 0.2%

Homeless Health Initiative and Allocated Funds
as of August 31, 2020

		Amount
Program Commitment		$100,000,000
Funds Allocation, approved initiatives:		
Be Well OC	$11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Housing Supportive Services	2,500,000	
Clinical Field Team Start-Up & Federal Qualified Health Center (FQHC)	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Day & QI Program	1,231,087	
FQHC Mobile Unit Claims	300,000	
FQHC Mobile Unit Staff	270,000	
Home Clinic Access Program (HCAP) Expansion - Telehealth and Clinical Field Team (CFT) On Call Days	1,000,000	
Funds Allocation Total		42,801,087
Program Commitment Balance, available for new initiatives:		$57,198,913

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.
This report only lists Board approved projects.

Budget Allocation Changes
Reporting Changes for August 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	Maintenance HW/SW – HR Corporate Application SW - SilkRoad	$12,000	To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses	2021

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
October 1, 2020

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network monitoring and audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- Compliance Program Effectiveness (CPE) Audit (applicable to OneCare and OneCare Connect):

  CalOptima is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis. As such, CalOptima has engaged an independent consultant to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program, as outlined in the CMS Medicare Parts C and D Program Audit Protocols.

  On August 17, 2020, CalOptima received a letter of engagement from the independent auditor. The audit, while normally onsite, will be held virtually from October 12 – 19, 2020.

2. PACE

- 2019 CMS Financial Audit:

  On August 13, 2020, CMS notified CalOptima PACE that it has been selected for the 2019 CMS Financial Audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS contracts with several Certified Public Accountant (CPA) firms to conduct the audits.

  The CPA firms will audit and inspect any books and records of the MAO that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract.

  More details will follow as soon as they become available. The audit date(s) have yet to be determined.

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3. Medi-Cal

- 2020 DHCS Medical Audit (Medi-Cal and OneCare Connect):

  The Department of Health Care Services' (DHCS) onsite audit of CalOptima took place from January 27, 2020 to February 7, 2020. The audit covered the review period of February 1, 2019 to January 31, 2020 and pertained to CalOptima's Medi-Cal program as well as elements of its OneCare Connect Medicaid-based services. DHCS reviewed an array of documents and data and conducted interviews with CalOptima staff as well as with a DHCS-selected delegate, Monarch HealthCare.

  On July 1, 2020, the DHCS provided its draft report which identified seven Medi-Cal (7) findings in the audit areas of Access and Availability of Care and Member's Rights. CalOptima did not receive any findings for State Supported Services or the Cal MediConnect program. On July 22, 2020, CalOptima notified the DHCS that it accepted the findings identified in the draft audit report.

  On August 11, 2020, the DHCS provided CalOptima with a final audit report and a formal request for a corrective action plan (CAP). CalOptima has already begun remediation of the deficiencies and submitted a CAP to the DHCS by the deadline of September 11, 2020.

B. Regulatory Notices of Non-Compliance

CalOptima did not receive any notices of non-compliance from its regulators for the month of August 2020.

C. Updates on Internal and Health Network Monitoring and Audits

For the months of April through June 2020, CalOptima's Audit & Oversight (A&O) department suspended monthly monitoring activities for internal CalOptima departments due to the COVID-19 pandemic. The A&O department resumed monthly monitoring activities for internal CalOptima departments in July 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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1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal Grievance & Appeals Resolution Services (GARS): Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved ≤ 30 Calendar Days of Receipt
January 2020	100%	100%	100%	0%	100%
February 2020	100%	100%	100%	25%	100%
March 2020	100%	100%	100%	0%	100%

  - Based on a focused review of eight (8) Medi-Cal standard appeals for the March 2020 file review, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level and one (1) acknowledgement letter did not include language assistance tag lines.

  - 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 appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely appeals.

- Medi-Cal GARS: Expedited Appeals

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Resolution of Expedited Appeals Resolved within 72 Hours of Receipt
January 2020	100%	100%	100%	0%	66.67%
February 2020	100%	100%	100%	0%	100%
March 2020	100%	N/A	100%	0%	100%

  - Based on a focused review of two (2) expedited Medi-Cal appeals for the March 2020 file review, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

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 expedited Medi-Cal appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely appeals.

- Medi-Cal GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances Resolved ≤ 30 Calendar Days of Receipt
January 2020	100%	100%	100%	20%	90%
February 2020	100%	100%	100%	20%	90%
March 2020	100%	100%	100%	22%	100%

- Based on a focused review of nine (9) Medi-Cal standard grievances for the March 2020 file review, the lower compliance score of 22% for the member notice content was due to the content not meeting the required 6th grade reading level and incomplete resolution letters.

- 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 Medi-Cal 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 to ensure accurate and timely grievances.

- Medi-Cal GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
January 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
February 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
March 2020	100%	N/A	100%	0%	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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- Based on a focused review of one (1) expedited Medi-Cal grievance for the March 2020 file review, the lower compliance score of 0% for the member notice content was due to an incomplete resolution.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of Medi-Cal expedited 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 to ensure accurate and timely grievances.

2. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved ≤ 30 Calendar Days of Receipt
January 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
February 2020	100%	100%	100%	0%	100%
March 2020	100%	100%	100%	0%	100%

- Based on a focused review of two (2) standard OneCare appeals for the March 2020 file review, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare standard appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely appeals.

- OneCare GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance Resolved ≤ 30 Calendar Days of Receipt
January 2020	100%	100%	100%	50%	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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February 2020	100%	100%	100%	0%	100%
March 2020	100%	100%	100%	0%	100%

- Based on a focused review of two (2) standard OneCare grievances for the March 2020 file review, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare 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 to ensure accurate and timely grievances.

3. Internal Monitoring: OneCare Connect [a\]

   - OneCare Connect GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved ≤ 30 Calendar Days of Receipt
January 2020	100%	100%	100%	0%	100%
February 2020	100%	100%	100%	16.67%	100%
March 2020	100%	100%	100%	0%	100%

- Based on a focused review of eight (8) OneCare Connect standard appeals for the March 2020 file review, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect standard appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely appeals.

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 GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance Resolved ≤ 30 Calendar Days of Receipt
January 2020	100%	100%	100%	0%	100%
February 2020	100%	100%	100%	20%	100%
March 2020	100%	90%	100%	20%	100%

  - Based on a focused review of ten (10) OneCare Connect standard grievances for the March 2020 file review, the lower compliance score of 90% for acknowledgement timeliness was due to one (1) untimely acknowledgment.

  - Based on a focused review of ten (10) grievances for the March 2020 file review of OneCare Connect standard grievances, the lower compliance score of 20% for the member notice content was due to the content of multiple notices not meeting the required 6th grade reading level and incomplete resolution.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect 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 to ensure accurate and timely grievances.

4. Internal Auditing: PACE [a\]

- By way of background and as previously reported, CalOptima's Audit & Oversight department conducted a full-scope audit of CalOptima's PACE during the first quarter of 2020. The core operational areas were reviewed for compliance with universe, timeliness, and clinical decision-making requirements. The audit areas included:

  - After Hour Calls
  - Appeals
  - Grievances
  - List of Personnel
  - Participant Medical Records
  - Quality Assessment Initiatives
  - Service Delivery Requests

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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- Below is a status update on the thirteen (3) deficiencies identified:
  - Resolved: 2 deficiencies
  - Partially Resolved: 9 deficiencies
  - Not Resolved: 2 deficiencies

- Corrective action plans (CAPs) identified as "Not Resolved" are due to reports provided not demonstrating evidence of compliance with requirements.

- CAPs identified as "Partially Revolved" are due to the following reasons:
  - Trainings not being able to take place due to site closures for PACE Alternative Care Settings (ACS)
  - No grievances and appeals available between June 1, 2020 – September 1, 2020 to validate compliance with requirements

5. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

  - Audit & Oversight (External), with approval from the Audit & Oversight Committee and Compliance Committee, suspended the review of UM Medi-Cal files for the months of March through May 2020, as a result of the COVID – 19 pandemic. Health networks under sanction were not exempt and continued to provide files for UM's monthly monitoring. Monitoring results for the health networks under sanction are reflected in the April and May 2020 file review results below. Monthly monitoring resumed in July 2020 (based on data from June) for all delegates.

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified	Letter Score for Modified	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
April 2020	89%	78%	95%	80%	90%	89%	94%	84%	69%	80%	Nothing to Report	Nothing to Report	Nothing to Report
May 2020	90%	95%	98%	95%	95%	90%	96%	55%	84%	95%	Nothing to Report	Nothing to Report	Nothing to Report
June 2020	90%	91%	95%	91%	85%	87%	94%	79%	88%	95%	96%	75%	93%

  - Based on a focused review of select files, seven (7) health networks drove the lower compliance score for timeliness. Sixteen (16) out of the total ninety-nine (99) files received from the seven (7) health networks were deficient. Deficiencies for the lower scores for timeliness include the following:
    - Failure to meet timeframe for decision (routine – 5 business days)

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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- Failure to meet timeframe for member notification (2 business days)
- Failure to meet timeframe for provider initial notification (24 hours)

➢ Based on a focused review of select files, eight (8) health networks drove the lower compliance score for clinical decision making. Fifty-two (52) out of the total eighty-eight (88) files received from the eight (8) health networks were deficient. Deficiencies for the lower scores for clinical decision making include the following:
- Failure to have appropriate professional make decision
- Failure to obtain adequate clinical information
- Failure to cite criteria for decision

➢ Based on a focused review of select files, five (5) health networks drove the lower compliance letter score. Twenty-three (23) out of the total forty-six (46) files received from the five (5) health networks were deficient. Deficiencies for the lower letter scores include the following:
- Failure to describe why the request did not meet criteria in lay language
- Failure to provide letter with description of services in lay language

➢ Based on the overall universe of Medi-Cal authorizations for May 2020, CalOptima's health networks received an overall compliance score of 99.95% for timely processing of routine authorization requests and a compliance score of 98.54% for timely processing of expedited authorization requests.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

6. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
April 2020	70%	N/A	99%	95%	99%	Nothing to Report	Nothing to Report	Nothing to Report
May 2020	93%	N/A	72%	100%	84%	100%	100%	92%
June 2020	95%	100%	91%	99%	93%	100%	82%	98%

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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- Audit & Oversight (External), with approval from the Audit and Oversight Committee, suspended file review of UM OneCare files for the months of March 2020 through May 2020, as a result of the COVID – 19 pandemic. Health networks under sanction were not exempt and continued to provide files for UM's monthly monitoring. Monitoring results for the health networks under sanction are reflected in the April and May 2020 file review results below. Monthly monitoring resumed in July 2020 (based on data from June) for all delegates.

- Based on a focused review of select files, only one (1) health network drove the lower compliance score for timeliness. Only one (1) file was deficient out of the eight (8) files received from the health network. The deficiency for the lower score for timeliness includes the following:
  - Failure to meet timeframe for provider written notification (2 business days)

- Based on a focused review of select files, four (4) health networks drove the lower compliance score for clinical decision making (CDM). Five (5) files out of the total eleven (11) files received from the four (4) health networks were deficient. The deficiency for the lower score for CDM includes the following:
  - Failure to cite criteria for decision

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for May 2020, CalOptima's health networks received an overall compliance score of 99.59% for timely processing of standard Part C authorization requests and 55% for timely processing of expedited Part C authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- <u>OneCare Claims</u>: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
May 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
June 2020	92%	97%	95%	97%

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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- Audit & Oversight (External), with approval from the Audit and Oversight Committee, suspended file review of Medi-Cal claims files for the months of March 2020 through May 2020, as a result of the COVID – 19 pandemic. Monitoring results for the health networks under sanction are reflected in the April and May 2020 file review results below. Monthly monitoring resumed in July 2020 (based on data from June) for all delegates.

6. Based on the overall universe of OneCare claims for CalOptima's health networks for May 2020, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
   - 80.73% for non-contracted clean claims paid or denied within 30 calendar days of receipt
   - 90.27% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

7. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
April 2020	100%	N/A	97%	100%	100%	67%	100%	93%	75%	75%	89%
May 2020	100%	N/A	84%	100%	82%	100%	92%	92%	65%	89%	97%
June 2020	96%	100%	94%	94%	93%	99%	94%	99%	95%	90%	96%

- Audit & Oversight (External), with approval from the Audit and Oversight Committee, suspended file review of UM OneCare Connect files for the months of March 2020 through May 2020, as a result of the COVID – 19 pandemic. Health networks under sanction were not exempt and continued to provide files for UM's monthly monitoring. Monitoring results for the health networks under sanction are reflected in the April and May 2020 file review results below. Monthly monitoring resumed in July 2020 (based on data from June) for all delegates.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of select files, four (4) health networks drove the lower compliance score for timeliness. Eleven (11) out of the total eighty-four (84) files received from the four (4) health networks were deficient. Deficiencies for the lower scores for timeliness were due to 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 initial notification (24 hours)
  - Failure to meet timeframe for provider written notification (24 hours)

- Based on a focused review of select files, three (3) health networks drove the lower compliance letter score. Five (5) out of the total eighteen (18) files received from the three (3) health networks were deficient. Deficiencies for the lower letter scores include the following:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language
  - Failure to provide referral back to primary care provider (PCP) on denial letter

- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for May 2020, CalOptima's health networks received an overall compliance score of 99.90% for timely processing of routine authorization requests and 100% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- <u>OneCare Connect Claims</u>: Professional Claims

  - Audit & Oversight (External), with approval from the Audit and Oversight Committee, suspended file review of Claims OneCare Connect files for the months of March through May 2020, as a result of the COVID – 19 pandemic. Monitoring results for the health networks under sanction are reflected in the April and May 2020 file review results below. Monthly monitoring resumed in July 2020 (based on data from June) for all delegates.

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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Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
May 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
June 2020	91%	86%	92%	97%

- Based on a focused review of select files, the lower compliance score for paid claims timeliness for June 2020 was driven by two (2) health networks with seventeen (17) files marked deficient for timeliness out of the total thirty-seven (37) files received from the two (2) health networks.

- Based on a focused review of select files, the lower compliance score for paid claims accuracy for June 2020 was driven by three (3) health networks with thirteen (13) files marked deficient for accuracy out of the total forty-one (41) files received from the three (3) health networks.

- Based on a focused review of select files, the lower compliance score for denied claims timeliness for June 2020 was driven by one (1) health network with fourteen (14) files marked deficient for timeliness out of the total eighteen (18) files received from the health network.

- Based on a focused review of select files, the lower compliance score for denied claims accuracy for June 2020 was driven by one (1) health network with one (1) file marked deficient for accuracy out of the eight (8) files received from the health network.

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for May 2020, CalOptima's health networks received the following overall compliance scores:
  - 79.30% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt.
  - 98.45% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt.
  - 99.02% 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

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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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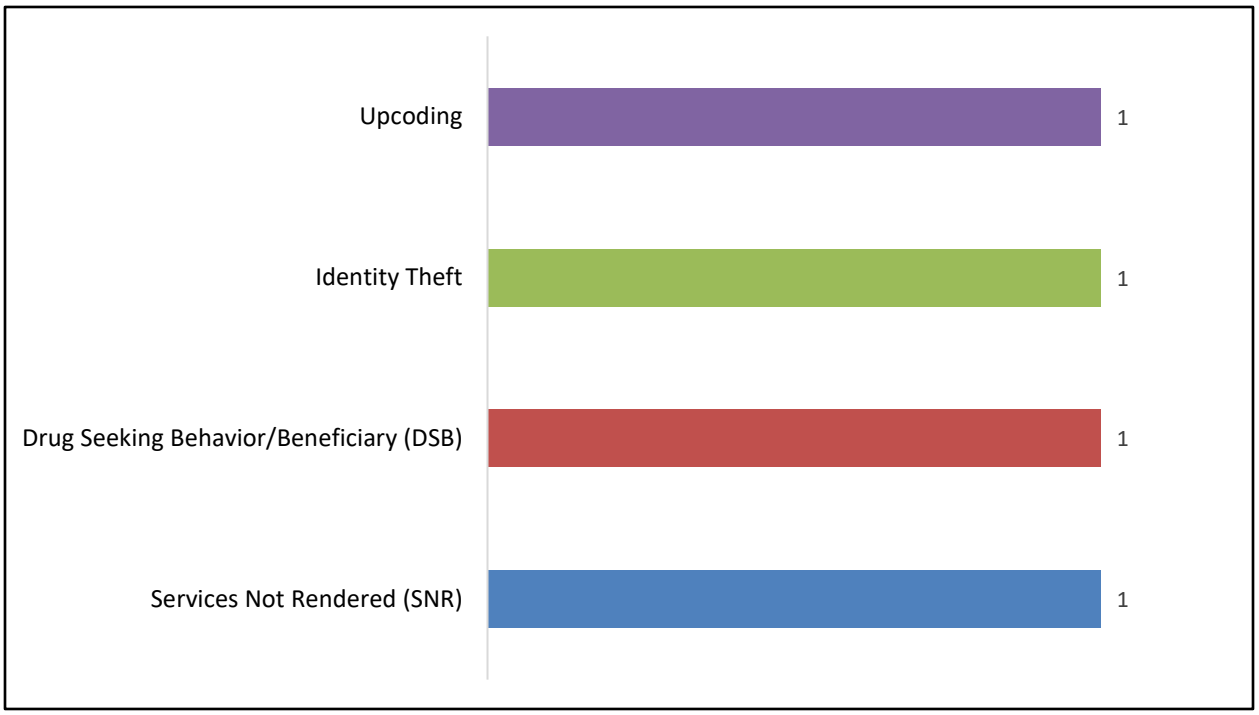
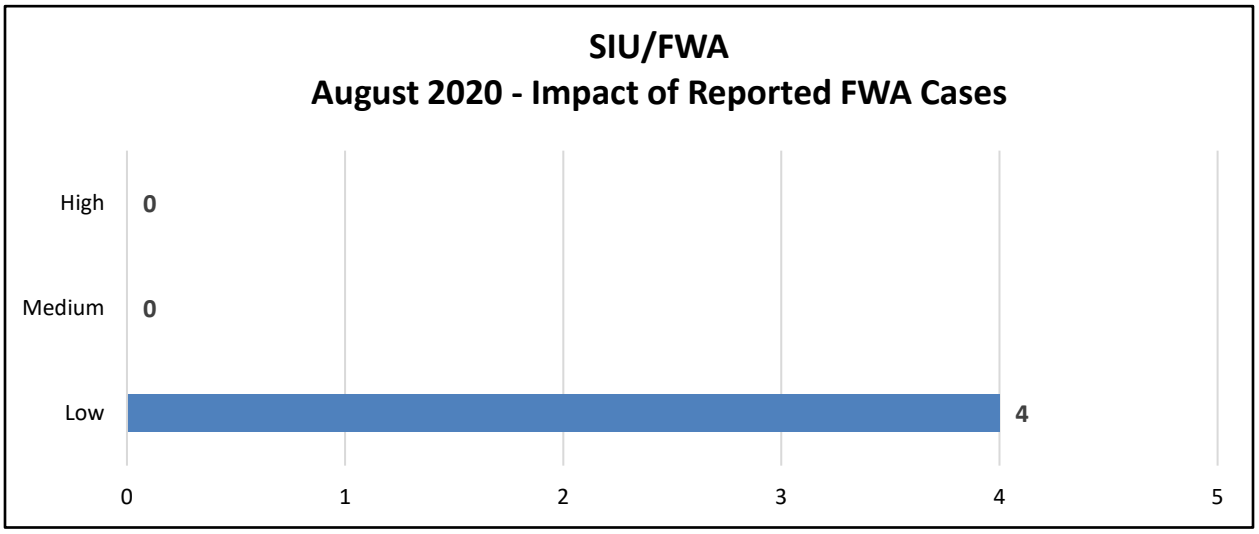
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in August 2020)





Total Number of Referrals Reported to DHCS (State)	4
Total Number of Referrals / Fraud Cases Reported to DHCS and MEDIC	0
Total Number of Referrals Reported	**4**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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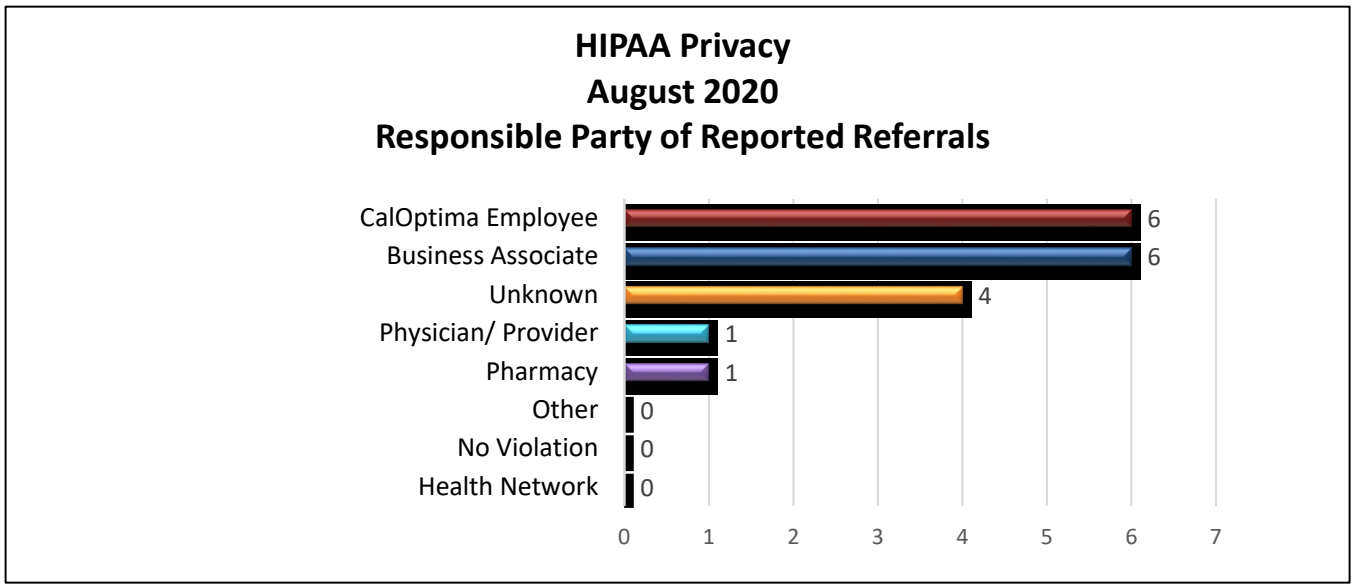
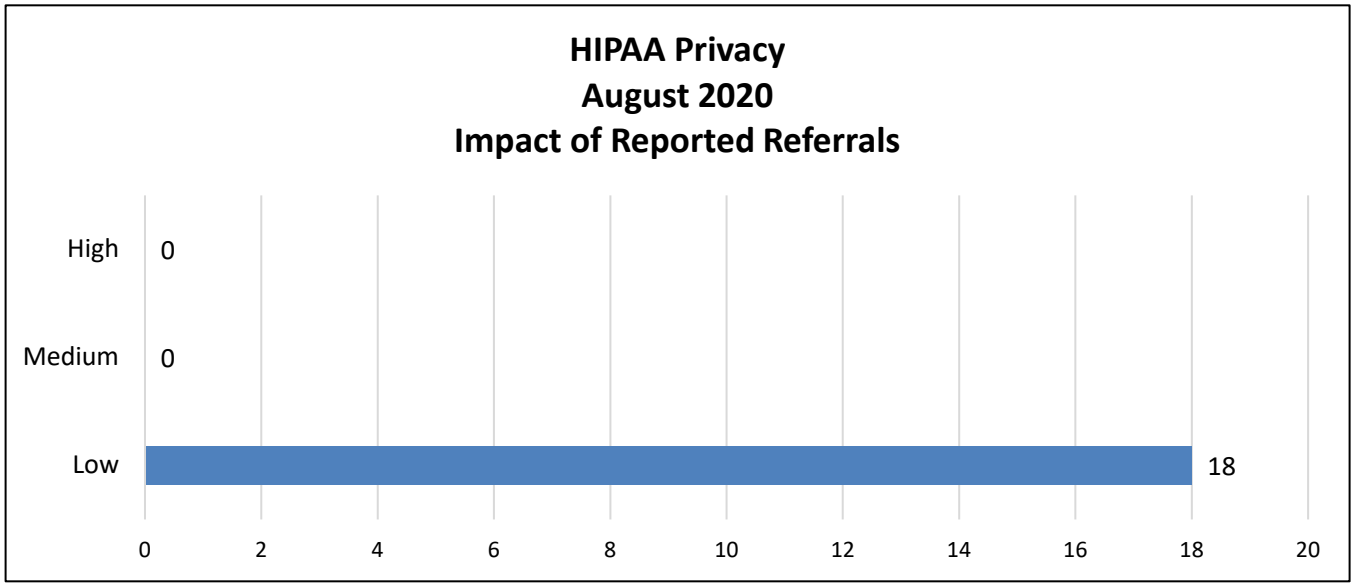
E. Privacy Update: (August 2020)





Total Number of Referrals Reported to DHCS (State)	18
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**18**

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

September 14, 2020

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: September Board of Directors Report

Despite periodic communications between Democratic leaders and the White House during the August recess, the two sides have not reached an agreement on the next COVID-19 relief package. Meanwhile, lawmakers aim to keep the government open past the end of the fiscal year on September 30 by passing a short-term stopgap measure that will punt the next spending fight at least through Election Day. This report covers congressional developments through September 14, 2020.

COVID-19 Relief Legislation

Negotiations are stalled on a "Phase 4" COVID-19 relief package, and there is little sign that congressional Democrats and the Administration are nearing a bipartisan agreement. Senate Republicans' Health, Economic Assistance, Liability Protection, and Schools (HEALS) Act, released in late July, totaled about $1 trillion; House Speaker Nancy Pelosi (D-CA) proposed a package that totals more than $3 trillion along the lines of the House-passed HEROES Act but has said publicly that she could "come down one trillion dollars if Republicans come up one trillion dollars" for a package worth about $2.2 trillion. Democrats are also pressing for the package to include state and local relief, supplemental funding for the Postal Service, a significant federal investment in COVID-19 testing and contact tracing, and an extension of enhanced unemployment benefits at $600 per week.

A Senate GOP "skinny" relief bill failed on a 52-47 procedural vote on September 10, with all Democrats and one Republican voting against advancing the measure. The scaled-down package totaled about $300 billion after offsets and included: liability protections for businesses operating during the pandemic; additional funding for testing and contact tracing; $10 billion in funding for the Postal Service; an extension of enhanced unemployment benefits at $300 per week; another round of Paycheck Protection Program (PPP) small business loans; and $105 billion in education funds, including for schools that are reopening. Democrats decried the bill as inadequate and continue to call for passage of a comprehensive package.

FY 2021 Appropriations

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While the House passed 10 of its 12 appropriations bills before adjourning for the August recess, the Senate Appropriations Committee has yet to move any FY 2021 spending bills out of committee, thus ensuring that Congress will need to pass a continuing resolution (CR) prior to the end of September to keep the government open and operating. House Majority Leader Steny Hoyer (D-MD) has said the House will vote on a CR the week of September 20.

Democratic leaders and Administration officials have agreed to negotiate a CR separately from the Phase 4 package. This raises the likelihood that Congress will pass a relatively "clean" bill with few non-appropriations policy provisions. As in past years, a CR will either keep the government open until December, allowing lawmakers more time either to pass pending appropriations legislation in the lame-duck session, or extend until early 2021 after the new session of Congress begins.

Lame Duck and Extenders

The post-election "lame duck" session will run from about November 9 to December 18, depending on the length of the continuing resolution. This is often an active period legislatively, and there are a number of items on the congressional agenda.

Many of the health care "extender" provisions included in the CARES Act, for example, are set to expire on November 30 and could be attached to a spending vehicle this fall. The CARES Act extended funding for community health centers, the National Health Service Corps, the Teaching Health Center Graduate Medical Education Program, and the Special Diabetes Program. In addition, the Certified Community Behavioral Health Centers (CCBHC) demonstration was reauthorized and two new states were added to the demonstration. Other Medicare extenders include the Work Geographic Practice Cost Index (GPCI) Floor and the National Quality Forum. The CARES Act also extended several expiring Medicaid programs—such as the Money Follows the Person demonstration and Medicaid spousal impoverishment protections—and delayed scheduled Medicaid disproportionate share hospital (DSH) payment reductions until December 1, 2020.

There are "must-pass" items that may also be addressing during the lame duck. The House and Senate each passed versions of the FY 2021 National Defense Authorization Act (NDAA) in July, with funding under the FY20 NDAA set to expire at the end of the month. Congress appears likely to complete negotiations of a final NDAA during the lame-duck session, as conferees have yet to be named to reconcile the differences between the two bills. Other measures set to expire at the end of September include surface transportation authorization (FAST Act), the National Flood Insurance Program, the National Institutes of Health authorization, the $25 billion in CARES Act aid to commercial passenger airlines, and the

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Workforce Innovation and Opportunity Act. In addition, Temporary Assistance for Needy Families (TANF) will expire at the end of November.

MFAR Withdrawn

On September 14, Centers for Medicare and Medicaid Services (CMS) Seema Verma announced via Twitter that the agency is withdrawing the Medicaid Fiscal Accountability Regulation (MFAR) rule from the regulatory agenda. In announcing the withdrawal, Administrator Verma highlighted "concerns that have been raised by our state and provider partners about potential unintended consequences of the proposed rule, which require further study."

Provider Relief Fund

The Department of Health and Human Services (HHS) continues to distribute payments from the Provider Relief Fund, which has received $175 billion to date. The deadline for the $15 billion Phase 2 General Distribution for Medicaid and Children's Health Insurance Program (CHIP) was extended several times and closed on September 13. The Phase 2 General Distribution was initially announced for state Medicaid and CHIP providers and was subsequently expanded to include certain Medicare providers, including those who missed Phase 1 General Distribution payment equal to two percent of their total patient care revenue or had a change in ownership in 2019 or 2020. Recently, HHS also announced that assisted living facilities were eligible to apply for the Phase 2 funding. Separately, HHS on September 3 announced the details of a $2 billion Provider Relief Fund performance-based incentive payment distribution to nursing homes. Unlike previous distributions, these payments will be tied to outcomes related to mortality and infection control. Nursing homes will not have to apply to receive the funds; HHS will measure nursing home performance through required data submissions.

As per the CARES Act, providers who receive payments through the Provider Relief Fund will be required to report on their use of the funds. According to a recently posted HHS notice document, health care providers that received more than $10,000 from the Provider Relief Fund will have to account for all the grant funds they spent in 2020 by February 15, 2021. The reporting system is set to open on October 1, 2020, and detailed instructions on reporting requirements are forthcoming.

Drug Pricing Executive Order

On September 13, President Trump signed an Executive Order on "Lowering Drug Prices by Putting America First." The order directs the Secretary of Health and Human Services (HHS) to move forward with rulemaking for a payment model to implement a "most-favored-nation" price for certain high-cost drugs and biologics in Medicare Part B. The benchmark would be based on

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the volume-adjusted lowest drug price available in any Organization for Economic Cooperation and Development (OECD) member country with per-capita gross domestic product similar to the U.S. Expanding on the Administration's previous International Pricing Index (IPI) proposal, the executive order also calls for HHS to develop and implement through rulemaking a second model that would extend a most-favored-nation pricing policy to certain Medicare Part D prescription drugs and biologics with "insufficient competition."

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

September 15, 2020

End of Session Update
Edelstein Gilbert Robson & Smith LLC

On Monday August 31, the Legislature adjourned for final recess, marking the end of the 2019-2020 legislative session. As we have detailed in previous updates, the 2020 legislative year has been the strangest in modern times. The COVID-19 pandemic has forced legislators out of the Capitol twice this year, both in the beginning of the stay-at-home order and in July as two Assemblymembers contracted the virus.

Republican Senator Brian Jones tested positive for COVID-19, throwing yet another curveball as the Legislature approached the end of session. Because the Republicans had continued to caucus in person and even held an in-person dinner, Senate Leadership prevented members who were exposed to Senator Jones at these events from attending floor session in person. Instead, members of the Republican caucus, with the exception of one Senator who did not attend these gatherings, were forced to stay home and vote remotely through Zoom.

Since the beginning of the pandemic, both houses have set procedures for remote voting in anticipation for a scenario like this one. While it has been used in select circumstances, the legality of remote voting has been questioned. It remains to be seen if there will be legal challenges regarding this decision.

Given the decision to quarantine nearly the entire Senate Republican caucus, tensions in the final days of session were high. The last hours of floor session were characterized by unprecedented conflict between Senate Republicans and Democrats, centered primarily around the fact that Republicans, being quarantined as they were, felt restricted in their ability to participate in the proceedings on the Senate floor.

As leadership worked to settle these disagreements, business on the Senate floor was delayed, leaving the house in a time crunch to take up the remaining bills on their agenda before midnight. The impacts of this time delay were also felt in the Assembly, whose members must wait for many bills to be sent over from the Senate for final passage. At the same time, both houses were holding bills hostage and Senate Republicans were accused of stalling to run out the clock.

In the end, due to the conflict in the Senate and bill hostage-taking, the clock struck midnight before several bills were heard on the floor on both houses. The bills that did pass out of both houses will be sent to the Governor who will have 30 days to consider the bills for his signature.

Many of the bills that did cross the finish line pertained to employment as the Legislature grappled with the issue of how business safely operate within the context of COVID-19.

Shortly after the adjournment of the Legislative Session, wildfires once ravaged the state. Tragically, whether you look at fatalities, structures burned, or acres burned, California sets new records every wildfire season. In 2020, the SCU, LNU, and August Complex fires have all made their way onto the top five list of destructive fires measured by size. Yet another California community, Berry Creek, has been destroyed by the Bear Fire. At least sixteen lives have been claimed by that fire which is burning just miles to the South East of the town of Paradise.

These disasters coupled with COVID-19 and power shut offs will be defining moments for the rest of Governor Newsom's career. We won't belabor that point but it's worth noting that challenges continue to mount.

Rumors have flown throughout 2020 that a special session might be called to allow the time strapped Legislature to return to the Capitol and finish its work. The Governor, who has to call a special session, was asked this week whether one was needed to respond to COVID-19 or wildfires. We weren't surprised to hear him dismiss the idea. Governor Newsom noted that infection rates were falling, the state was receiving mutual aid to fight fires, and there was nothing the Legislature could do to address the 14,000 lightning strikes, high temperatures, or high winds that have driven wildfires.

While those are all valid points, we suspect that the Legislature's behavior in 2020 might have even more to do with the Governor's reluctance.

As reported above, Senate Republicans were able to grind the Senate to a halt in the final hours of session after being helped along by mismanagement on the part of Democratic leadership. However, the Legislature has been heading this direction for months. Assembly and Senate leadership have been at each other's throats all year. It started when the Senate strong armed the Assembly into an unexpected recess on March 16 due to the pandemic. Since then, leaders have argued over everything from whether or not remote voting should be allowed, how many bills the Legislature should hear, and what topics should be covered. Consequently, by August 31, tensions were high. As the Senate failed to work through Assembly bills, Senate priorities were "held hostage" in the Assembly.

At the same time, Assembly Speaker Anthony Rendon landed himself in hot water with his management of his colleagues. As noted above, the Assembly has never seen eye to eye with the Senate on remote voting. The Speaker questions the legality of bills passed with remote votes. Assemblymember Buffy Wicks, who has a newborn daughter and is on maternity leave, requested permission from the Speaker to vote by proxy. When her vote was needed to pass several 2/3 vote bills on the final night of session, Assemblymember Wicks was not allowed to vote by proxy and chose to return to the Capitol with her newborn baby to cast her vote. This incident has become a major embarrassment for the Speaker and has garnered national attention.

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What Didn't Get Done?
Many priority bills failed to pass by midnight on August 31st.Three police reform bills didn't make the deadline. Collectively, these bills would have banned the use of some "less-lethal" force options against protesters, de-certified police officers with criminal records consistent with the state's treatment of doctors and lawyers, and opened police conduct records to public scrutiny. One of the authors of these bills has stated publicly that his bill, which was not taken up by the Assembly, would have had the votes to pass.

SB 1120, authored by Senate Pro Tem Toni Atkins, was another casualty of the end of session gamesmanship. The bill was a hard fought measure which would have overturned local zoning rules and allowed construction of duplexes in single family residential zones. The bill had the votes to pass out of the Assembly, but it wasn't taken up there until very late and wasn't transmitted to the Senate until 11:57. The Senate was not able to take the bill up in time to send it to the Governor and the Pro Tem has publicly accused the Speaker of holding the bill up in the Assembly.

Packaging reform measures designed to cut down on plastic waste also stalled. Split between two companion measures, the Senate passed the Assembly's vehicle but never transmitted it back to the Assembly so it could be voted on and sent to the Governor. Meanwhile the Assembly chose not to take up the Senate's bill until late into the night, and did not leave themselves enough time to marshal the votes they needed to pass it.

So Why Call a Special Session?
The above bills are just a few examples of many proposals that fell victim to the Legislature's mismanagement in 2020. While both houses are quick to point fingers at each other the truth is there was plenty of time to get work done if leadership was willing to negotiate and horse trade with each other and the Governor.

Governor Newsom accomplished his major goals including relief for renters, a budget, and enhanced protections for employees. There is no reason he cannot govern via executive order for the remainder of 2020. Even if he called the Legislature back, the end of session bitterness will not have worn off and it's questionable how much could get done. It's entirely possible that the Assembly and Senate will continue to take shots at each other even once they return in 2021.

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2019–20 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 266 McCollum	**Paycheck Protection Program and Health Care Enhancement Act:** Authorizes $483 billion to replenish segments of the CARES Act, expand coronavirus testing, and provide more support to hospitals and providers during this pandemic. Of the $483 billion, this bill includes: ■ $310 billion in funding for the Small Business Administration's PPP; ■ $10 billion for Economic Injury Disaster Loans; ■ $75 billion for the provider relief fund, managed by the Department of Health and Human Services, to cover treatment for COVID-19 patients and lost revenue from canceled elective procedures; and ■ $25 billion to research, develop, validate, manufacture, purchase, administer, and expand capacity for COVID-19 tests.	**04/24/2020** Signed into law **04/23/2020** Passed the House **04/21/2020** Passed the Senate **01/08/2019** Introduced	CalOptima: Watch
H.R. 748 Courtney	**CARES Act:** Authorizes $2.2 trillion in spending for health care and employment-related interventions. This includes: ■ $1.5 billion to support the purchase of personal protective equipment, lab testing, and other activities; ■ $127 billion to provide grants to hospitals, public entities, and nonprofits, and Medicare and Medicaid suppliers and providers to cover unreimbursed health care related expenses or lost revenues due to COVID-19; ■ $1.32 billion in supplemental funding for community health centers; ■ $955 million to support nutrition programs, home and community-based services, support for family caregivers, and expanded oversight for seniors and individuals with disabilities; ■ $945 million to support research on COVID-19; and ■ $425 million to increase mental health services.	**03/27/2020** Signed into law **03/27/2020** Passed the House **03/25/2020** Passed the Senate **01/24/2019** Introduced	CalOptima: Watch
H.R. 6201 Lowey	**Families First Coronavirus Response Act:** Allocates billions of federal funding support related to COVID-19. Funds are to be utilized for an emergency increase in the Federal Medical Assistance Percentages (FMAP) for Medicaid of 6.2%, emergency paid sick leave and unemployment insurance, COVID-19 testing at no cost, food aid and other provisions. Of note, on March 6, 2020, President Trump signed into law an emergency supplemental funding package of $8.3 billion for treating and preventing the spread of COVID-19.	**03/18/2020** Signed into law **03/17/2020** Passed the Senate **03/14/2020** Passed the House **03/11/2020** Introduced	CalOptima: Watch
H.R. 6462 Cisneros, Gallegos	**Emergency Medicaid for Coronavirus Treatment Act:** Would expand Medicaid eligibility to any American diagnosed with COVID-19 or any other illness that rises to the level of a presidential national emergency declaration. Additionally, would require Medicaid coverage for all COVID-19 treatment and testing to continue even after the national emergency is over.	**04/07/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 6666 Rush	**COVID-19 Testing, Reaching, and Contacting Everyone (TRACE) Act:** Would authorize the Centers for Disease Control and Prevention (CDC) to award grants for testing, contact tracing, monitoring, and other activities to address COVID-19. Those eligible to receive grant funding would include federally qualified health centers, nonprofit organizations, and certain hospitals and schools. Additionally, would allocate $100 billion for fiscal year 2020 for the disbursement of CDC grant funds.	**05/01/2020** Introduced	CalOptima: Watch
SB 89 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19:** Appropriates $500 million General Fund by amending the Budget Act of 2019. Funds will be allocated to any use related to Governor Newsom's March 4, 2020 State of Emergency regarding COVID-19. Additionally, authorizes additional appropriations related to COVID-19 in increments of $50 million, effective 72 hours following notification of the Director of Finance. Of note, the total amount appropriated to COVID-19 is not to exceed $1 billion.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch
AB 117 Ting	**Emergency Budget Response to COVID-19 at Schools:** Similar to SB 117, appropriate $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds would be distributed by the Superintendent of Public Instruction.	**05/22/2020** Bill died **03/16/2020** Amended and re-referred to the Senate Committee on Budget and Fiscal Review **12/03/2018** Introduced	CalOptima: Watch
SB 117 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19 at Schools:** Similar to AB 117, appropriates $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds will be distributed by the Superintendent of Public Instruction.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 275 **Pan, Leyva**	**Personal Protective Equipment:** Would require the State Department of Public Health to establish a personal protective equipment (PPE) stockpile to ensure an adequate supply of PPE for health care workers and essential workers. Would require the stockpile to have enough supplies for no less than a 45-day pandemic or other state or local health emergency. Additionally, would require general acute care hospitals, skilled nursing facilities, integrated health systems, and licensed dialysis clinics to maintain a 45-day stockpile of PPE. Would establish the Personal Protective Equipment Advisory Committee to make recommendations to the Department of Industrial Relations and State Department of Public Health regarding necessary types and amount of PPE, procurement and supply chain resilience, storage, and other best practices.	**09/04/2020** Enrolled with the Governor **08/31/2020** Passed Assembly floor **05/02/2019** Passed Senate floor **02/13/2019** Introduced	CalOptima: Watch CalPACE: Oppose

STATE BUDGET BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 79	**Human Services:** Enacts human services trailer bills in the California 2020-2021 budget. ■ Department of Developmental Services supplemental rate increases for specified providers including, independent living programs, infant development programs, and early start specialized therapeutic services ■ In-Home Supportive Services reassessment extensions due to delays related to COVID-19 and Governor Newsom's executive state of emergency order	**06/29/2020** Signed into law **06/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 80	**Public Health:** Enacts health care trailer bills in the California 2020-2021 budget. ■ Medi-Cal managed care capitated payment rate reduction of 1.5 percent for the 18-month bridge period ■ Implementation of a Medi-Cal risk corridor for the 18-month bridge period ■ Prop 56 value-based payments and supplemental payments ■ Extension of the Medi-Cal 2020 Demonstration ■ 340B Supplemental Payment Pool for non-hospital clinics ■ Expansion of full-scope Medi-Cal to seniors, regardless of immigration status ■ Extension of coverage for COVID-19 to uninsured individuals ■ Health Care Payment Data Program ■ Reimbursement for medication-assisted treatment services	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 81	**Public Health:** Enacts health care trailer bills in the California 2020-2021 budget. ■ Medi-Cal rate reimbursement methodology adjustments for skilled nursing facilities during the COVID-19 pandemic ■ Implementation of the skilled nursing facility quality assurance fee ■ County access to Mental Health Services Act funds for additional support related to COVID-19	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 83	**Housing:** Enacts housing trailer bills in the California 2020-2021 budget. ■ Funding to continue Project Roomkey ■ Bypassing certain California Environmental Quality Act (CEQA) regulations related to Project Roomkey	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 89	**Fiscal Year 2020-2021 California State Budget:** Enacts a $202.1 billion spending plan for Fiscal Year 2020-2021, with General Fund spending at $133.9 billion. The following included within the state budget will have a direct impact to Medi-Cal: ■ Funding to address Medi-Cal caseloads ■ Provisions to maintain Community Based Adult Services, the Multipurpose Senior Services Program, and other optional benefits ■ Funding to address the COVID-19 pandemic	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch

AFFORDABLE CARE ACT

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1425 Craig	**Patient Protection and Affordable Care Enhancement Act (PPACEA):** Would, among other things, lower health care costs through fair drug price negotiations, provide additional protections for those with preexisting health conditions, and offer 100 percent federal matching funds for states that choose to expand Medicaid under the Affordable Care Act. The bill also would reduce the Federal Medical Assistance Percentages for the fourteen remaining non-expansion states and permanently authorize the Children's Health Insurance Program.	**06/30/2020** Passed the House; Referred to the Senate **02/22/2020** Introduced	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 910 Wood	**Mental Health Services Dispute Resolution:** Would provide the Department of Health Care Services (DHCS) more authority to resolve coverage disputes between the specialty mental health plan (MHP) and the Medi-Cal managed care plan (MCP) if the MHP and the MCP are unable to do so within 15 days. Would require the MHP and the MCP to continue to provide mental health services during the DHCS review period. DHCS would have no more than 30 days to resolve the dispute to determine which agency is responsible for that Medi-Cal beneficiary.	**08/18/2020** Bill died **08/05/2020** Hearing canceled at the request of the author **06/23/2020** Referred to Senate Committee on Health **01/30/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch

Back to Agenda

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2265 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Would authorize MHSA funds to include treatment of a substance use disorder for an individual with cooccurring mental health and substance use disorders, when that individual is already eligible to receive mental health services through an MHSA-funded program. The authorization would apply across the state. Additionally, would require the county that elects to utilize MHSA funding for this purpose to report the number of people assessed for cooccurring mental health and substance use disorders and the number of those assessed who only have a substance use disorder to the Department of Health Care Services.	**09/01/2020** Enrolled with the Governor **08/28/2020** Passed Senate floor **06/02/2020** Passed Assembly floor **02/14/2020** Introduced	CalOptima: Watch Orange County Board of Supervisors: Support
AB 2266 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2265, would authorize MHSA funds to be used for a pilot program to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The pilot program would take place in 10 counties, including the County of Orange, beginning January 1, 2022 and ending on December 31, 2026.	**05/22/2020** Bill died **02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2576 Gloria	**Mental Health Services Act (MHSA) Use of Funds for Homelessness:** Would require a county to seek stakeholder input when establishing a plan to reallocate the use of MHSA funds. Additionally, would require counties utilizing MHSA funds for the provision of mental health services for those experiencing homelessness to report to the Legislature, each year, the number of individuals receiving services.	**08/18/2020** Bill died **07/01/2020** Referred to Senate Committee on Health **06/15/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch
SB 803 Beall	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Would create requirements for a Certified Peer Support Specialist (PSS) certification program by July 1, 2022. Would allow an individual 18 years of age or older, who has experienced a mental illness and/or a substance use disorder or is a parent or family member of such individual, to become a PSS. A PSS would be able to provide non-medical mental health and substance abuse support services in a county that opts in to establish a PSS certification program and funds the non-federal share of those services. This would also require the Department of Health Care Services to develop and implement billing codes, reimbursement rates, and claim requirements for the PSS program. Additionally, would require the Department to include PSS as a Medi-Cal provider type and PSS services as a distinct service type in participating counties.	**09/04/2020** Enrolled with the Governor **08/31/2020** Passed Assembly floor **06/24/2020** Passed Senate floor **01/08/2020** Introduced	CalOptima: Watch LHPC: Support Orange County Board of Supervisors: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 1254 Moorlach	**Capacity Determinations and Appointments of Guardians Ad Litem for Mentally Ill Adults Without a Conservator:** Would establish an additional procedure for the appointment of a guardian ad litem for a person who lacks the capacity to make rational informed decisions regarding medical care, mental health care, safety, hygiene, shelter, food, or clothing with a rational thought process due to a mental illness, defect, or deficiency. The bill would authorize certain persons to petition the court for the appointment of a guardian ad litem under these provisions.	**05/29/2020** Bill died **05/14/2020** Hearing canceled at the request of the author. **05/11/2020** Referred to Committee on Judiciary **02/21/2020** Introduced	CalOptima: Watch

BLOOD LEAD SCREENINGS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2276 Reyes	**Blood Lead Screening Tests Age Guidelines:** Would require the Medi-Cal managed care plan (MCP) to ensure blood lead screening tests for a Medi-Cal beneficiary at 12 and 24 months of age by doing the following: ■ Identify, on a quarterly basis, every child beneficiary that has missed a blood screening test; ■ If a test was missed, notify the beneficiary's health care provider of the requirements to perform a test and provide guidance to the parent/guardian; ■ Contract with providers qualified to conduct any blood level screening tests; ■ Submit to the Department of Health Care Services, on an annual basis and upon request, a record of every beneficiary under six years of age that has missed a blood screening test, including the age at which a test was missed; and ■ If a parent/guardian declines a recommended screening, ensure that the parent/guardian signs a statement of refusal to be documented in the child's medical record.	**09/01/2020** Enrolled with the Governor **08/29/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/14/2020** Introduced	CalOptima: Watch
AB 2277 Salas	**Blood Lead Screening Tests Contracted Providers:** Would require the Medi-Cal managed care plan (MCP) to identify beneficiaries who have missed a blood screening test at both 12 and 24 months of age and impose requirements of the contracted provider to conduct blood lead screenings tests for those eligible to receive such tests. Would require the MCP to remind the contracted provider to conduct blood lead screening tests on a quarterly basis and to notify the beneficiary's parent, parents, guardian, or other person responsible for their care that the beneficiary is eligible to receive a blood screening test.	**08/18/2020** Bill died **07/01/2020** Referred to Senate Committee on Health **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/14/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2278 Quirk	**Childhood Lead Poisoning Prevention Health Plan Identification:** Would require the name of the health plan financially liable for conducting blood lead screenings tests to be reported by the laboratory to the Department of Health Care Services once the screening test has been completed. The name of the health plan is to be reported for each Medi-Cal beneficiary who receives the blood lead screen tests.	**05/29/2020** Bill died **03/04/2020** Amended and re-referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2279 Garcia	**Childhood Lead Poisoning Prevention Risk Factors:** Would require the following risk factors be included in the standard risk factors guide, which are to be considered during each beneficiary's periodic health assessment: ■ A child's residency or visit to a foreign country ■ A child's residency in a high-risk ZIP Code ■ A child's relative who has been exposed to lead poisoning ■ The likelihood of a child placing nonfood items in the mouth ■ A child's proximity to current or former lead-producing facilities ■ The likelihood of a child using food, medicine, or dishes from other countries	**08/18/2020** Bill died **06/23/2020** Referred to Senate Committee on Health **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/14/2020** Introduced	CalOptima: Watch
AB 2422 Grayson	**Blood Lead Screening Tests Medi-Cal Identification Number:** Would require the Medi-Cal identification number to be added to the list of patient identification information collected during each blood test. Would require the laboratory conducting the blood lead screening tests to report all patient identification information to the Department of Health Care Services.	**05/22/2020** Bill died **02/27/2020** Referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch
SB 1008 Leyva	**Childhood Lead Poisoning Prevention Act Online Registry:** Would require the Department of Public Health to design, implement, and maintain an online lead information registry available to the general public. Would require the information registry to include items such as the location and status of properties being inspected for lead contaminants.	**05/29/2020** Bill died **05/12/2020** Rescinded due to shortened 2020 Legislative Calendar **03/05/2020** Referred to Committees on Health; Judiciary **02/14/2020** Introduced	CalOptima: Watch

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2042 Wood	**CalAIM Enhanced Care Management and In-Lieu-Of Services:** Similar to SB 916, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	**05/22/2020** Bill died **03/16/2020** Amended and re-referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
AB 2055 Wood	**CalAIM Drug Medi-Cal and Behavioral Health:** Would require the Department of Health Care Services to establish the Behavioral Health Quality Improvement Program. The Behavioral Health Quality Improvement Program would be responsible for providing support to entities managing the Drug Medi-Cal program as they prepare for any changes directed by the CalAIM initiative. Additionally, would establish a voluntary intergovernmental transfer (IGT) program relating to substance use disorder treatment provided by counties under the Drug Medi-Cal program. The IGT program would fund the nonfederal share of supplemental payments and to replace claims based on certified public expenditures.	**05/22/2020** Bill died **03/17/2020** Amended and re-referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
AB 2170 Blanco Rubio	**CalAIM Medi-Cal Eligibility for Juveniles Who are Incarcerated:** Would require the county welfare department to conduct a redetermination of eligibility for juveniles who are incarcerated so that, if eligible, their Medi-Cal would be reinstated immediately upon release.	**05/22/2020** Bill died **02/20/2020** Referred to Committee on Health **02/11/2020** Introduced	CalOptima: Watch
SB 910 Pan	**CalAIM Population Health Management:** Would require Medi-Cal managed care plans (MCPs) to implement the population health management program for those deemed eligible, effective January 1, 2022. Would require the Department of Health Care Services to utilize an external quality review organization (EQRO) to evaluate the effectiveness of the enhanced care management and in-lieu-of services provided to beneficiaries by each MCP. Additionally, would require each MCP to consult with stakeholders, including, but not limited to, county behavioral health departments, public health departments, providers, community-based organizations, consumer advocates, and Medi-Cal beneficiaries, on developing and implementing the population health management program.	**05/29/2020** Bill died **03/16/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
SB 916 Pan	**CalAIM Enhanced Care Management and In-Lieu-Of Services:** Similar to AB 2042, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	**05/29/2020** Bill died **03/16/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4618 McBath	**Medicare Hearing Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of hearing aids for Medicare beneficiaries. Hearing aids would be provided every five years and would require a prescription from a doctor or qualified audiologist.	**1/24/2020** Passed the Committee on Energy and Commerce **10/08/2019** Introduced	CalOptima: Watch
H.R. 4650 Kelly	**Medicare Dental Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of dental health services for Medicare beneficiaries. Covered benefits would include preventive and screening services, basic and major treatments, and other care related to oral health.	**1/24/2020** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
H.R. 4665 Schrier	**Medicare Vision Act of 2019:** No sooner than January 1, 2022, would require Medicare Part B to cover the cost of vision care for Medicare beneficiaries. Covered benefits would include routine eye exams and corrective lenses. Corrective lenses covered would be either one pair of conventional eyeglasses or contact lenses.	**1/24/2020** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
AB 1904 Boerner Horvath	**Maternal Physical Therapy:** Would include pelvic floor physical therapy for women post-pregnancy as a Medi-Cal benefit.	**05/22/2020** Bill died **01/17/2020** Referred to Committee on Health **01/08/2020** Introduced	CalOptima: Watch
AB 1965 Aguiar-Curry	**Human Papillomavirus (HPV) Vaccine:** Would expand comprehensive clinical family planning services under the program to include the HPV vaccine for persons of reproductive age.	**05/22/2020** Bill died **03/17/2020** Hearing canceled at the request of the author **01/30/2020** Referred to Committee on Health **01/21/2020** Introduced	CalOptima: Watch
AB 2258 Reyes	**Doula Care:** Would require full-spectrum doula care to be included as a covered benefit for pregnant and postpartum Medi-Cal beneficiaries. The program would be established as a 3-year pilot program in 14 counties, including the County of Orange, beginning July 1, 2021. Prior authorization or cost-sharing to receive doula care would not be required.	**05/22/2020** Bill died **02/20/2020** Referred to Committee on Health **02/13/2020** Introduced	CalOptima: Watch

DENTAL

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2535 Mathis	**Denti-Cal Education Pilot Program:** Would establish a 5-year pilot program to provide education and training to Denti-Cal providers providing care to individuals who attend a regional center and are living with a developmental disability. Additionally, Denti-Cal providers who participate in the pilot program and complete the required continuing education units would be eligible for a supplemental provider payment. The supplemental provider payment amount has yet to be defined by the Department of Health Care Services.	**05/22/2020** Bill died **03/17/2020** Hearing postponed by the committee **02/27/2020** Referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office projects this expansion would cost approximately $900 million General Fund (GF) in 2019-2020 and $3.2 billion GF each year thereafter, including the costs if In-Home Supportive Services.	**08/18/2020** Bill died **07/02/2019** Hearing canceled at the request of the author **06/06/2019** Referred to Senate Committee on Health **05/28/2019** Passed Assembly floor **12/03/2018** Introduced	CalOptima: Watch CAHP: Support LHPC: Support
AB 526 Petrie-Norris	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Similar to SB 1073, would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**08/21/2020** Bill died **08/30/2019** Senate Committee on Appropriations; Held under submission **06/27/2019** Passed Senate Committee on Health **05/23/2019** Passed Assembly floor **02/13/2019** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 683 Carrillo	**Adjusting the Assets Test for Medi-Cal Eligibility:** Would eliminate specific assets tests, such as life insurance policies, musical instruments, and living trusts, when determining eligibility for Medi-Cal enrollment, effective July 1, 2020. Additionally, would prohibit the Department of Health Care Services from using an asset and resource test when determining eligibility for Medi-Cal enrollment when the individual is enrolled in the Medicare Shared Savings Program, effective January 1, 2020.	**08/18/2020** Bill died **06/23/2020** Referred to Senate Committee on Health **01/20/2020** Passed Assembly floor; Referred to Senate floor **02/15/2019** Introduced	CalOptima: Watch
SB 29 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million General Fund, $21 federal funds) by expanding full-scope Medi-Cal to approximately 25,000 adults who are undocumented and 65 years of age and older. The financial costs for In-Home Supportive Services is estimated to cost $13 million General Fund.	**08/31/2020** Bill died; Moved to inactive file **08/30/2019** Passed Assembly Appropriations Committee **05/29/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
SB 1073 Gonzalez	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Similar to AB 526, would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**05/29/2020** Bill died **04/03/2020** Amended and re-referred to Committee on Health **02/18/2020** Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1978 Correa/Lieu	**Fighting Homelessness Through Services and Housing Act:** Similar to S. 923, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the Committee on Financial Services	CalOptima: Watch
S. 923 Feinstein	**Fighting Homelessness Through Services and Housing Act:** Similar to H.R. 1978, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the Committee on Health, Education, Labor, and Pensions	CalOptima: Watch Orange County Board of Supervisors: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1907 Santiago, Gipson, Quirk-Silva	**California Environmental Quality Act (CEQA) Exemption for Emergency Shelters and Supportive Housing:** Would exempt the development of emergency shelters, supportive housing or affordable housing by a public agency from CEQA regulations, expiring on December 31, 2028.	**05/22/2020** Bill died **05/13/2020** Hearing canceled at the request of the author **01/30/2020** Referred to Committees on Natural Resources; Housing and Community Development **01/08/2020** Introduced	CalOptima: Watch
AB 2295 Quirk-Silva	**Fairview Developmental Center:** Would require the State Legislature to enact legislation relating to the development of the Fairview Developmental Center (Center) located in Costa Mesa, CA. Of note, the Governor's Fiscal Year 2019-2020 budget included funds to utilize the Center temporarily to provide housing and services for those experiencing a severe mental illness. Additionally, AB 1199, signed into law in 2019, allows a public hearing to determine the use of the Center. This bill is still early in the legislative process. The pending legislation to define use of the Center is unknown at this time.	**05/29/2020** Bill died **02/14/2020** Introduced	CalOptima: Watch
AB 2746 Petrie-Norris, Gabriel	**Accountability of State Funds Used for Homelessness:** Would require any entity that receives state funds for programs related to homelessness, including, but not limited to, the Whole-Person Care pilot program, California Work Opportunity and Responsibility to Kids (CalWORKs), or the Housing and Disability Income Advocacy Program, to submit a report regarding the use of state funds. The report would be sent annually to the state agency granting funds for the program.	**09/04/2020** Enrolled with the Governor **08/30/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/20/2020** Introduced	CalOptima: Watch
AB 2848 Santiago	**Homelessness Reduction Plan:** Would require each city or county to develop a plan to reduce homelessness by no less than 10% each year through a state mandate. The plan would be effective no later than January 1, 2022 and would be under the direction of the state's Homeless Coordinating and Financing Council. Additionally, would authorize the Office of the Inspector General to be in compliance with the Homeless Reduction Plan.	**05/22/2020** Bill died **05/05/2020** Amended and re-referred to Committee on Housing and Community Development **02/20/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 3269 Chiu, Bloom, Bonta, Quirk-Silva, Santiago	**State and Local Homelessness Reduction Plan:** Would require the State Homeless Coordinating and Financing Council (coordinating council) to seek federal support from the Department of Housing and Urban Development (HUD), if available, to conduct a statewide needs and gaps analysis relating to homelessness. Would require the coordinating council to identify state programs that provide housing or services to individuals experiencing homelessness. With that information, would require the coordinating council to collaborate with HUD to create a financial model that will assess the costs of providing transitional support into permanent housing for those experiencing homelessness. Furthermore, this bill would require state and local agencies aim at reducing homelessness by 90% by December 31, 2028, based on the 2019 homeless point-in-time count. Would establish the Office of the Housing and Homelessness Inspector General to monitor the reduction plan and to bring action against a state and local agency that fails to adopt and implement a homelessness reduction plan within a reasonable time frame. Additionally, on or before January 1, 2022, each state and local agency shall develop an actionable plan to reduce homelessness and submit that plan to the Homeless Coordinating and Financing Council. This bill would also require HUD to set a benchmark goal for the reduction plan for each state and local agency to meet by January 1, 2028.	**08/21/2020** Bill died **08/20/2020** Senate Committee on Appropriations; Held under submission **08/06/2020** Passed Senate Committee on Housing; Referred to Senate Committee on Appropriations **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/21/2020** Introduced	CalOptima: Watch
AB 3300 Bloom, Bonta, Gipson, Quirk-Silva, Santiago, Wicks	**California Access to Housing and Services Act:** Would authorize the Department of Finance to allocate no more than $2 billion General Fund to establish the California Access to Housing and Services Fund.	**08/18/2020** Bill died **08/04/2020** Hearing postponed by the committee **07/01/2020** Referred to Senate Committee on Housing **06/15/2020** Passed Assembly floor; Referred to Senate floor **02/21/2020** Introduced	CalOptima: Watch

MEDI-CAL MANAGED CARE PLANS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2625 Boerner Horvath	**Ground Emergency Medical Transportation (GEMT):** Would require managed care plans that offers coverage for GEMT services to include those services as in-network services.	**05/22/2020** Bill died **03/02/2020** Referred to Committee on Health **02/20/2020** Introduced	CalOptima: Watch
AB 2836 Chen	**Medi-Cal Emergency Medical Transportation Reimbursement Act:** Would impose a quality assurance fee (QAF) for each emergency medical transport provided by an emergency medical transport provider, beginning Fiscal Year 2021-2022. Would require the Department of Health Care Services to calculate the annual QAF to a specified program period at least 150 days before the start of the fiscal year. The bill would also redefine "emergency medical transport provider" to mean any provider of emergency medical transports, except during the entirety of any Medi-Cal managed care rating period.	**05/22/2020** Bill died **05/05/2020** Amended and re-referred to Committee on Health **02/20/2020** Introduced	CalOptima: Watch
SB 936 Pan	**Medi-Cal Managed Care Plans Contract Procurement:** Would require the Department of Health Care Services Director to conduct a contract procurement at least once every five years with a contracted commercial Medi-Cal managed care plan providing care for Medi-Cal beneficiaries on a state-wide or limited geographic basis.	**05/29/2020** Bill died **04/03/2020** Amended and re-referred to Committee on Health **02/06/2020** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1938 Low, Eggman	**340B Discount Drug Purchasing Program:** Would define a "designated entity" eligible for the 340B discount drug purchasing program as a nonprofit organization, including any subsidiary of that organization, that individually or collectively meets specific requirements. This would require: ■ The designated entity to be a licensed managed care organization that has previously contracted with the department as a primary care case management organization; ■ The designated entity to be contracted with the federal Centers for Medicare and& Medicaid Services (CMS) to provide services in the Medicare Program as a Medicare special needs plan; and ■ The designated entity to be an existing participant of the 340B program. Additionally, would prohibit a designated entity from using any revenue from a contract with the Department of Health Care Services, a contract with CMS, and from the 340B program for specific activities, such as: ■ Funding litigation under the California Environmental Quality Act; or ■ Influencing or funding any ballot measure actions related to housing.	**06/05/2020** Bill died **05/18/2020** Passed Committee on Health; Referred to Committee on Appropriations **01/17/2020** Introduced	CalOptima: Watch
AB 2100 Wood	**Pharmacy Carve-Out Benefit:** Would require the Department of Health Care Services to establish the Independent Prescription Drug Medical Review System (IPDMRS) for the outpatient pharmacy benefit, and to develop a framework for the system that models the requirements of the Knox-Keene Health Care Service Plan Act, no sooner than January 1, 2021. Would require the IPDMRS to review disputed health care service of any outpatient prescription drug eligible for coverage and payment by the Medi-Cal program that has been denied, modified, or delayed or to a finding that the service is not medically necessary. Additionally, would require a minimum 180 days for continuity of care for medications regardless if listed on the Medi-Cal contract drug list. Would allow the Department to provide a disease management payment to contracted pharmacies for specialty drugs in order to ensure beneficiary access.	**09/01/2020** Enrolled with the Governor **08/28/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/05/2020** Introduced	CalOptima: Watch
AB 2348 Wood	**Pharmacy Benefit Management (PBM):** Would require a PBM, who contracts with a health care service plan, beginning on October 1, 2021, to report to the Department of Managed Health Care the PBM's revenue, expenses, health care service plan contracts, the scope of services provided to that plan, and the number of enrollees the PBM serves. The PBM would also be required to submit a report on all covered prescription drugs, including generic, brand name, and specialty drugs dispenses at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use.	**05/22/2020** Bill died **05/05/2020** Amended and re-referred to the Committee on Health **02/18/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 852 Pan	**California Affordable Drug Manufacturing Act of 2020:** Would require the California Health and Human Services Agency (CHHSA) to enter into partnerships with one or more drug companies or generic drug manufacturers, licensed by the United States Food and Drug Administration, to produce or distribute generic prescription drugs, including at least one form of insulin, in order to reduce the cost of prescription drugs. Would require CHHSA to study and report to the Legislature on the feasibility of the State directly manufacturing and selling generic prescription drugs, no later than July 1, 2023.	**09/02/2020** Enrolled with the Governor **08/31/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **01/13/2020** Introduced	CalOptima: Watch CAHP: Support
SB 1084 Umberg	**Secure Dispensing of a Controlled Substance:** Would require a pharmacist who dispenses a controlled substance in a pill form to dispense the controlled substance in a lockable vial no sooner than June 30, 2021. Would require the manufacturer of the controlled substance to reimburse the pharmacy dispensing the medication the cost of using a lockable vial within 30 days of receiving a claim. Would also require the pharmacy to provide educational pamphlets to the patient regarding the use of a controlled substance.	**05/29/2020** Bill died **05/12/2020** Rescinded due to shortened 2020 Legislative Calendar **03/05/2020** Referred to Committees on Business, Professions and Economic Development; Judiciary **02/19/2020** Introduced	CalOptima: Watch

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2492 Choi	**Program of All-Inclusive Care for the Elderly (PACE) Enrollment:** Would require the Department of Health Care Services to establish a maximum number of eligible participants each PACE center can enroll.	**05/22/2020** Bill died **03/17/2020** Hearing postponed by Committee on Aging & Long-Term Care **03/12/2020** Referred to Committees on Health; Aging & Long-Term Care **02/19/2019** Introduced	CalOptima: Watch CalPACE: Oppose

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2604 Carrillo	Pandemic and Health-Related Emergency Protocols for Health Facilities Act: During a health-related state of emergency or local emergency, would require a health facility to limit the possible introduction of a pathogen, infection, or illness that is related to a pandemic or emergency by: ■ Postponing non-emergency medical procedures or office visits; ■ Prohibiting or limiting visitors of patients to the health facility; ■ Ensuring all patients and staff are always wearing surgical masks or personal protective equipment; ■ Providing education and enforcing regarding hand hygiene and cough etiquette for patients and staff; ■ Regularly disinfecting the health facility at least three times per day; ■ Adding air cleaning equipment to ventilation systems; ■ Establishing contaminated, partially contaminated, and clean zones with buffers between each of the three zones; ■ Implementing outdoor triage stations; and ■ Considering all patients to have "suspected cases' of the pathogen, infection, or illness until ruled out or confirmed.	**05/22/2020** Bill died **05/07/2020** Amended and re-referred to Committee on Labor and Employment **02/21/2020** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 890 Wood	**Nurse Practitioners:** Would establish the Nurse Practitioner Advisory Committee to provide recommendations and advice to the Board of Registered Nursing. Would permit a nurse practitioner to practice without direct, ongoing supervision of a physician when practicing in an office managed by one or more physicians. Would also require the Board of Registered Nursing to define the minimum requirements for which a nurse practitioner may transition to practice without the direct, ongoing supervision of one or more physicians. If a nurse practitioner meets the minimum requirements, this bill would then authorize that nurse practitioner to perform specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances.	**09/04/2020** Enrolled with the Governor **08/31/2020** Passed Senate floor **01/27/2020** Passed Assembly floor **02/20/2019** Introduced	CalOptima: Watch LHPC: Support

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 66 Atkins/ McGuire	**Federally Qualified Health Center (FQHC) Reimbursement**: Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that do not allow an FQHC to be reimbursed for a mental or dental and physical health visits on the same day. A patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit through the member's primary care provider and a mental health or dental visit as two separate visits, regardless if at the same location on the same day. As a result, the patient would no longer have to wait a 24-hour time period in order to receive medical and dental or mental health services, while ensuring that clinics are appropriately reimbursed for both services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**08/31/2020** Bill died **09/11/2019** Moved to inactive filed at the request of the Majority Leader **08/30/2019** Passed Assembly Committee on Appropriations **05/23/2019** Passed Senate floor **01/08/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Co-Sponsor, Support
AB 2871 Fong	**Drug Medi-Cal Reimbursement Rates:** Would require the Department of Health Care Services to establish reimbursement rates for services provided through the Drug Medi-Cal program to be equal to rates for similar services provided through the Medi-Cal Specialty Mental Health Services program.	**05/22/2020** Bill died **03/05/2020** Referred to Committee on Health **02/21/2020** Introduced	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4932 Thompson	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to S. 2741, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Committees on Energy and Commerce; Ways and Means	CalOptima: Watch AHIP: Support

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 Committee on Finance	CalOptima: Watch AHIP: Support
AB 1676 Maienschein	**Telehealth Mental Health Services for Children, Pregnant Women, and Postpartum Persons:** Would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than January 1, 2021. Consultation and treatment services, provided by a psychiatrist, would be accessible during standard business hours, with the option for evening and weekend hours. Would also require adequate staffing to ensure calls are answered within 60 seconds. Payment structure has yet to be defined.	**01/31/2020** Bill died **05/16/2019** Committee on Appropriations; Held under submission **04/24/2019** Passed Committee on Health **02/22/2019** Introduced	CalOptima: Watch CAHP: Oppose
AB 2164 Rivas, Salas	**Expanding Access to Telehealth:** Would no longer require the first visit at a federally qualified health clinic to be an in-person visit by authorizing telehealth appointments that occur by synchronous real time or asynchronous store and forward. This would allow the new patient the option to utilize telehealth services and become an established patient as their first visit. This would only apply during the COVID-19 pandemic and up to 180 days post-termination of the state of emergency.	**09/01/2020** Enrolled with the Governor **08/28/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/11/2020** Introduced	CalOptima: Watch LHPC: Support
AB 2360 Maienschein	**Mothers and Children Mental Health Support Act of 2020:** Would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than July 1, 2021. Would permit telehealth services to be conducted by video or audio-only calls. Additionally, would require the telehealth consultation appointment to be completed by a mental health clinician with expertise in providing care for pregnant, postpartum, and pediatric patients. Would require access to a psychiatrist when deemed appropriate or requested by the treating provider.	**09/01/2020** Enrolled with the Governor **08/28/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/19/2020** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 1278 Bradford	**Health Care Provider License for Telehealth:** Would require that accepted standards of practice applicable to a health care provider under the health care provider's license shall also apply to that health care provider while providing telehealth services.	**05/29/2020** Bill died **05/15/2020** Hearing canceled at the request of the author **03/05/2020** Referred to Committee on Business, Professions and Economic Development **02/21/2020** Introduced	CalOptima: Watch

TRAILER BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
Trailer Bill Medi-Cal Expansion	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals 65 years of age or older regardless of their immigration status. The Governor's Fiscal Year 2020-2021 proposed budget anticipates the expansion of full-scope Medi-Cal will cost $80.5 million ($62.4 million General Fund) in 2021 and $350 million ($320 million General Fund) each year after, including the cost of In-Home Supportive Services.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Drug Price Negotiations	**Med-Cal Drug Pricing Negotiations:** Would authorize the Department of Health Care Services negotiate "best prices" with drug manufacturers, both within and outside of the United States, and to establish and administer a drug rebate program in order to collect rebate payments from drug manufacturers for drugs furnished to California residents who are ineligible for full-scope Medi-Cal. Would authorize a Medi-Cal beneficiary to receive more than six medications without prior approvals. Additionally, this Trailer Bill would modify the current co-pay amount for a drug prescription refill.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Medication-Assisted Treatment	**Medication-Assisted Treatment (MAT):** Would expand narcotic treatment program services to include MAT under Drug Medi-Cal.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
Trailer Bill Managed Care Savings and Efficiencies	**Managed Care Savings and Efficiencies:** In alignment with the 2020-2021 State Budget May Revise, would reduce Medi-Cal capitation rate increments by up to 1.5 percent for capitation rates associated with the July 1, 2019 through December 31, 2020 rate period. Additionally, the Department of Health Care Services (DHCS) would be able to apply these reduced capitation rates for rating periods starting on or after January 1, 2021 and to account for the impacts of the COVD-19 public health emergency. To ensure capitation rates are actuarily sound, DHCS would be required to evaluate the impact of the changes in the level of health care funding for health care services on capitation rates it develops and pays under any applicable managed care health plan contract with a Medi-Cal managed care plan.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Federally Qualified Health Center and Rural Health Clinic Prospective Payment System Carve-Outs	**Elimination of Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Prospective Payment System (PPS) Carve-Outs for Pharmacy and Dental Services:** Would require all Medi-Cal covered services provided by an FQHC or RHC, including but not limited to pharmacy and dental services, to be reimbursed only through the clinic's PPS rate, effective January 1, 2021. If an FQHC or RHC is unable to revert to its prior base PPS rate, it would be required to adjust the FQHC or RHC PPS base rate through scope-of-service adjustments. Of note, this Trailer Bill language would exclude any payment changes for services related to specialty mental health and Drug Medi-Cal.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Proposition 56 Payments	**Sunset of Proposition 56 Value-Based Payments:** In alignment with the 2020-2021 State Budget May Revise, would eliminate the Proposition 56 Value-Based Payment Program for provider incentive payments, effective July 1, 2020.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill COVID-19 Medi-Cal Response	**COVID-19 Medi-Cal Response:** Would require the Department of Health Care Services to implement any federal Medicaid program waivers or flexibilities approved by the Centers for Medicare & Medicaid Services related to the COVID-19 pandemic, pending approval from the State Department of Finance. Additionally, would require DHCS to continue providing COVID-19 related testing and treatment for individuals currently uninsured, regardless of immigration status, through Medi-Cal fee-for-service. This would be in effect for the duration of the State of Emergency.	**05/22/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Nursing Facility Financing Reform	**Nursing Facility Financing Reform:** Would make modifications to the skilled nursing facility (SNF) Quality Assurance Fees (QAFs): ■ Would exempt a unit that provides freestanding pediatric subacute care services in a SNF from the QAF for the rate period of August 1, 20202 through December 31, 2020, and every subsequent calendar year after; ■ Would allow the Department of Health Care Services (DHCS) to enforce new mechanisms for the collection of delinquent QAFs; and ■ Expand the use of the SNF Quality and Accountability Special Fund to December 31, 2021. Additionally, would adjust the Medi-Cal reimbursement rate methodology for the rate period of August 1, 2020 to December 31, 2020 to be no less than the rates established for 2019-2020 and no more than the applicable federal upper payment limit.	**05/26/2020** Published on the Department of Finance website	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
Trailer Bill Long-Term Care at Home	**Long-Term Care at Home:** Would include long-term care services at home as a Medi-Cal covered benefit for beneficiaries enrolled in managed care and fee-for-service. Would require the entity providing long-term care at home benefits to be licensed and certified by the California Department of Public Health. Additionally, would require the benefit to include services such as, health assessments, transitional care services, care coordination, and home- and community-based services.	**06/12/2020** Published on the Department of Finance website	CalOptima: Watch

*Information in this document is subject to change as bills are still going through the early stages of the legislative process.

CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: September 8, 2020

2020 Federal Legislative Dates

April 4–19	Spring recess
August 10–September 7	Summer recess
October 12–November 6	Fall recess

2020 State Legislative Dates*

**Due to COVID-19, 2020 State Legislative dates have been modified*

January 6	Legislature reconvenes
January 31	Last day for bills introduced in 2019 to pass their house of origin
February 21	Last day for legislation to be introduced
April 2–12	Spring recess
May 22	Last day for policy committees to hear and report bills to fiscal committees introduced in the Assembly
May 29	Last day for policy committees to hear and report bills to fiscal committees introduced in the Senate
May 29	Last day for policy committees to hear and report to the floor non-fiscal bills introduced in the Assembly
June 5	Last day for fiscal committees hear and report to the floor bills introduced in the Assembly
June 15	Budget bill must be passed by midnight
June 15–19	Assembly floor session only
June 19	Last day for the Assembly to pass bills in their house of origin
June 19	Last day for fiscal committees to hear and report to the floor bills introduced in the Senate
June 22–26	Senate floor session only
June 26	Last day for the Senate to pass bills in their house of origin
July 2–July 27one	Summer recess
July 31	Last day for policy committees to hear and report fiscal bills to fiscal committees
August 7	Last day for policy committees to meet and report bills to the floor
August 14	Last day for fiscal committees to report bills to the floor
August 17–31	Floor session only
August 21	Last day to amend bills on the floor
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 3	General Election
December 7	Convening of the 2021–22 session

Sources: 2020 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan), and the Program of All-Inclusive Care for the Elderly (PACE).

Board of Directors Meeting
October 1, 2020
CalOptima Community Outreach Summary — September 2020

Background
CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events and public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.

- Branding: The event/activity promotes awareness of CalOptima in the community.

- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima's staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Event Update

For more than 40 years, the American Cancer Society has hosted The Great American Smokeout on the third Thursday in November to encourage smokers and vapers to give up these unhealthy habits of smoking and vaping. CalOptima's Population Health Management (PHM) team launched efforts to increase awareness internally with staff in 2016 and expanded their reach in the community in 2018 and 2019. This year, PHM is supporting this national awareness campaign to serve our members and community by hosting a virtual "Escape the Vape" event on Thursday, November 19, 2020, from 5:30–7:30 pm.

CalOptima is collaborating with key stakeholders to educate Orange County youth from elementary to high school on the dangers of smoking and vaping. Led by Orange County's youth, activities will include anti-vaping presentations, youth led interview with the lost cords (American Cancer Society volunteers who lost their vocal cords due to smoking) and performance videos. PHM has invited all Orange County school districts to engage youth in anti-smoking and anti-vaping contests to encourage them to live tobacco-free lives and an opportunity to win rewards.

CalOptima has been working closely with key organizations focused on tobacco efforts to engage youth throughout the county. Community partners include the American Cancer Society, Tobacco Use Prevention Program at the Orange County Health Care Agency, Orange County Tobacco Education Coalition, Orange County Department of Education, The National Council on Alcoholism and Drug Dependence – Orange

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County, 1-866-New-Lung, The G.R.E.E.N Foundation, The City of Anaheim Ponderosa Family Resource Center, Anaheim School District, Santa Ana School District, Waymakers and Inside The Outdoors.

In response to COVID-19, CalOptima is hosting the Escape the Vape event using a virtual platform to ensure the health and safety of event participants, community partners and staff. Using a virtual platform may also provide opportunity for greater participation. For additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities
CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

As of August 24, 2020, through virtual meetings and teleconferences CalOptima expects to participate in 26 community events, coalition and committee meetings during September.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
9/01/2020	• Collaborative to Assist Motel Families Meeting (Virtual Meeting)
9/03/2020	• Continuum of Care Homeless Provider Forum (Virtual Meeting) • Garden Grove Community Collaborative Advisory Meeting (Virtual Meeting)
9/08/2020	• Orange County Cancer Coalition Meeting (Virtual Meeting) • Wellness and Prevention Coalition Meeting (Virtual Meeting)
9/10/2020	• Kid Healthy Community Advisory Council (Virtual Meeting) • Buena Park Collaborative Meeting (Virtual Meeting) • State Council on Developmental Disabilities Regional Advisory Committee Meeting (Virtual Meeting) • Orange County's Annual SoCal Alzheimer's Disease Research Conference hosted by UCI MIND and Alzheimer's Orange County (Sponsorship Fee: $250 included company's logo and web link on event website, logo on event e-communications, event social media posts and on rotating slides during event) (Virtual Conference)
9/11/2020	• Orange County Diabetes Collaborative Meeting (Format Pending)
9/14/2020	• Orange County Veteran's and Military Families Collaborative Meeting (Virtual Meeting) • Fullerton Collaborative Meeting (Virtual Meeting)
9/15/2020	• Aging and Disability Resource Center Advisory Committee Meeting (Virtual Meeting) • Placentia Collaborative Meeting (Virtual Meeting) • North Orange County Senior Collaborative Meeting (Virtual Meeting)

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9/16/2020	• Orange County Communications Workgroup Meeting (Teleconference) • La Habra Community Collaborative Meeting (Virtual Meeting) • Covered Orange County Steering Committee Meeting (Teleconference)
9/17/2020	• Orange County Children's Partnership Committee Meeting (Virtual Meeting) • Orange County Strategic Plan for Aging Data Task Force Meeting (Virtual Meeting)
9/21/2020	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting (Virtual Meeting)
9/23/2020	• Vendor Fair hosted by UC Irvine Health Medical Center (Virtual Event)
9/24/2020	• Orange County Care Coordination for Kids Meeting (Virtual Meeting) • Orange County Women's Health Project Advisory Board Meeting (Virtual Meeting)
9/28/2020	• Stanton Collaborative Meeting (Virtual Meeting) • Community Health Research and Exchange (Virtual Meeting)

As of August 24, 2020, CalOptima expects to organize or convene four community stakeholder events, meetings or presentations through virtual meetings or teleconferences during September.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
9/17/2020	• Health Network Forum (Virtual Meeting)

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
9/10/2020	• Community-Based Organization Presentation for Westminster Family Resource Center's members — Topic: Medi-Cal in Orange County (Vietnamese and Spanish Virtual Presentations) • Community-Based Organization Presentation for Buena Park Collaborative's members — Topic: Medi-Cal in Orange County (English Virtual Presentations)
9/11/2020	• Community-Based Organization Presentation for Cal State Fullerton Nursing Students — Topic: Medi-Cal in Orange County (English Virtual Presentations)

CalOptima provided zero endorsements consistent with CalOptima Policy AA. 1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo, since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

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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 opportunity to increase awareness of CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

In response to the COVID-19, CalOptima has transitioned how we engage with our community partners and is not attending in-person community collaborative meetings. In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19. CalOptima continues its participation in community collaborative meetings and community events by attending virtual meetings and events; CalOptima also looks for additional ways to support our community partners by providing CalOptima informing materials and, if requested and criteria are met, by providing branded items. With respect to events that have been cancelled or postponed due to COVID-19 in which sponsorship or fees have already been paid, event organizers were provided the option to refund previously pre-paid participation fees or apply paid sponsorship fees to any future events,

provided the future event(s) meet the criteria set forth in Policy AA.1223 and meets eligibility requirements indicated by Board of Directors.

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

October

Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Thursday, 10/1 9–11 a.m. (Virtual format)	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 10/1 11 a.m.–1 p.m. (Virtual format)	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Courtyard Center 12732 Main St. Garden Grove
Friday-Saturday,10/2-10/3 Time: 9 a.m.–2 p.m. (Virtual format)	+CHOC Children's Hospital Mental Health Live Webinar	Conference Registration required	Sponsorship $1,000 7 Staff	Virtual Platform
Friday, 10/2 9-11:30am (Virtual format)	++Foster and Homeless Liaison Network Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Orange County Department of Education 200 Kalmus Dr. Costa Mesa
Tuesday, 10/6 9:30–11 a.m. (Virtual format)	++ Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 10/7 9–10:30 a.m. (Virtual format)	++ Orange County Aging Services Collaborative General Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 10/7 10:30–12 p.m. (Virtual format)	Orange County Healthy Aging Initiative and Orange	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Alzheimer's OC 2515 McCabe Way Irvine

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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	County Strategic Plan for Aging Healthcare Committee			
Thursday, 10/8 10–11:30 a.m. (Virtual format)	+Aurrera Health Group Orange County Advocate Fair: 2020-21 OneCare Connect Benefits	Health/Resource Fair Open to the Public	3 Staff	Virtual Platform
Thursday, 10/8 10–11:30 a.m. (Virtual format)	++Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Buena Park Community Center 6640 Beach Blvd. Buena Park
Thursday, 10/8 11 a.m.–12:30 p.m. (Virtual format)	++ Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 10/8 12:30–1:30 p.m. (Conference call)	++ Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Hive 1725 S. Douglas Rd. Anaheim
Monday, 10/12 1–2:30 p.m. (Virtual format)	++ Orange County Veterans and Military Families Collaborative - Children and Family Working Group	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 10/12 2:30–3:30 p.m. (Virtual format)	++ Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 10/13 10–11:30 a.m. (Virtual format)	++Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Susan G. Komen OC 2817 McGaw Ave. Irvine
Tuesday, 10/13 3:30–5:30 p.m. (Virtual format)	++Wellness and Prevention Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	189 Avenida La Cuesta San Clemente
Wednesday, 10/14 1:30–3:30 p.m. (Conference call)	++Health Care Task Force Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	State Council on Developmental Disabilities 2000 E. Fourth St. Santa Ana

Thursday, 10/15 2–3:30 p.m. (Virtual format)	*Health Network Forum	Steering Committee Meeting: Open to Collaborative Members	10+ Staff	Virtual Platform
Thursday, 10/15 2–3:30 p.m. (Virtual format)	++Orange County Disability Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 10/15 2:30–4:30 p.m. (Virtual format)	++Orange County Women's Health Project Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Village in Santa Ana 1505 E. 17th St. Santa Ana
Monday, 10/19 1–4 p.m. (Virtual format)	++ OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Delhi Community Center 505 E. Central Ave. Santa Ana
Tuesday, 10/20 11 a.m.–12 p.m. (Conference call)	++Placentia Community Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Placentia Library 411 Chapman Ave. Placentia
Tuesday, 10/20 1-2:30pm (Virtual format)	++Aging and Disability Resource Connection Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual Platform
Wednesday, 10/21 9–10:30 a.m. (Conference call)	++ Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Village 1505 E. 17th St. Santa Ana
Wednesday, 10/21 3:30–4:30 p.m. (Conference call)	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Location varies
Thursday, 10/22 1:30–3:30 p.m. (Virtual format)	++ Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	1 Staff	CHOC Centrum Building 1120 W. La Veta Orange
Monday, 10/26 12:30–1:30 p.m. (Virtual format)	++Community Health Research and Exchange Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Healthy Smiles for Kids 2101 E. Fourth St. Santa Ana
Monday, 10/26 12:30–1:30 p.m. (Virtual format)	++ Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Stanton Civic Center 7800 Katella Ave. Stanton
Wednesday, 10/28 9–10:30 a.m. (Virtual format)	*Cafecito Meeting	Steering Committee Meeting: Open to Collaborative Members	3 Staff	Virtual Platform

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Action
Recommend accepting and receiving and filing the Fiscal Year (FY) 2019-20 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP

Background
CalOptima has contracted with financial auditors Moss-Adams, LLP since May 21, 2015, to complete CalOptima's annual financial audit. At the May 21, 2020 meeting of the CalOptima Finance and Audit Committee, Moss-Adams presented the 2020 Audit Plan. The plan includes performing the mandatory annual consolidated financial statement audit and drafting the consolidated financial statements for the year ending June 30, 2020.

Discussion
Moss-Adams conducted the interim audit from May 18, 2020 through May 22, 2020 and the year-end audit remotely during July to August 2020. The significant audit areas that Moss-Adams reviewed included:

- Medical claims liability and claims expense;
- Capitation revenue and receivables;
- Amounts due to State of California or the California Department of Health Care Services;
- Pension and other post-employment benefits (OPEB) liabilities; and
- Impact of COVID-19.

Proposed Adjustment
During this year's review, Moss-Adams recommended one proposed adjustment to reclassify approximately $92 million to properly reflect Cash and Cash Equivalents (CCE) and Investments within the Current Assets category of CalOptima's June 30, 2020, Balance Sheet. CalOptima concurred with the auditor's recommendation and recorded the proposed adjustment. Since this reclassification is made within the same asset category, it does not impact CalOptima's overall financial position.

Following are the auditor's recommendation, Staff will use Trade Date instead of Report Date to determine the classification between CCE and Investment going forward.

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Category	Account Name	Debit	Credit
Balance Sheet - Current Assets	Cash and Cash Equivalents (CCE)		$92 million
Balance Sheet - Current Assets	Investment	$92 million	

Unmodified Opinion
Overall, the results from FY 2020 audit were positive with Moss-Adams issuing an Unmodified Opinion that CalOptima's Financial Statements are presented fairly and in accordance with U.S. Generally Accepted Accounting Principles (GAAP).

The auditor made no additional changes in CalOptima's approach to applying critical accounting policies, noted no material weaknesses, nor reported having encountered any significant difficulties during the audit. As such, Management recommends that the Board accept the CalOptima FY 2020 audited financial statements, as presented.

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

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

Attachments
1. FY 2019-20 CalOptima Audited Financial Statements
2. Presentation by Moss-Adams, LLP

/s/ Richard Sanchez — *09/23/2020*
Authorized Signature — **Date**

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REPORT OF INDEPENDENT AUDITORS AND
FINANCIAL STATEMENTS
WITH SUPPLEMENTARY INFORMATION

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

June 30, 2020 and 2019

MOSSADAMS

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Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Management's Discussion and Analysis

The intent of management's discussion and analysis of CalOptima's financial performance is to provide readers with an overview of the agency's financial activities for the fiscal years ended June 30, 2020, 2019, and 2018. Readers should review this summation in conjunction with CalOptima's financial statements and accompanying notes to the financial statements to enhance their understanding of CalOptima's financial performance.

Key Operating Indicators

The table below compares key operating indicators for CalOptima for the fiscal years ended June 30, 2020, 2019, and 2018:

Key Operating Indicators	2020	2019	2018
Members (at end of fiscal period):			
Medi-Cal program	742,769	743,936	763,824
OneCare	1,452	1,537	1,418
OneCare Connect	14,358	14,123	14,768
PACE	391	327	267
Average member months			
Medi-Cal program	724,049	751,409	772,511
OneCare	1,463	1,448	1,372
OneCare Connect	14,144	14,398	15,079
PACE	380	303	239
Operating revenues (in millions)	$ 3,833	$ 3,475	$ 3,446
Operating expenses (in millions)			
Medical expenses	3,644	3,217	3,292
Administrative expenses	142	131	132
Operating income (in millions)	$ 47	$ 127	$ 22
Operating revenues PMPM (per member per month)	$ 432	$ 377	$ 364
Operating expenses PMPM			
Medical expenses PMPM	410	349	348
Administrative expenses PMPM	16	14	14
Operating income PMPM	$ 6	$ 14	$ 2
Medical loss ratio	95%	93%	96%
Administrative expenses ratio	4%	4%	4%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	$ 67	$ 137	$ 143
Administrative expenses (in millions)	$ 75	$ 137	$ 143

Overview of the Financial Statements

This annual report consists of financial statements and notes to those statements, which reflect CalOptima's financial position as of June 30, 2020, 2019, and 2018, and results of its operations for the fiscal years ended June 30, 2020, 2019, and 2018. The financial statements of CalOptima, including the statements of net position, statements of revenues, expenses and changes in net position, and statements of cash flows, represent the accounts and transactions of the five (5) programs – Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly ("PACE"), and CalOptima Foundation.

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

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

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

The following discussion and analysis addresses CalOptima's overall program activities. CalOptima's Medi-Cal program accounted for 90.3 percent, 90.2 percent, and 89.8 percent of its annual revenues during fiscal years 2020, 2019, and 2018, respectively. CalOptima's OneCare program accounted for 0.4 percent, 0.6 percent, and 0.5 percent of its annual revenues during fiscal years 2020, 2019, and 2018, respectively. CalOptima's OneCare Connect program accounted for 8.3 percent, 8.4 percent, and 9.1 percent of its annual revenues during fiscal years 2020, 2019, and 2018, respectively. All other programs consolidated accounted for 1.0 percent, 0.8 percent, and 0.6 percent of CalOptima's annual revenues during fiscal years 2020, 2019, and 2018, respectively.

CalOptima Foundation (the "Foundation") was formed as a not-for-profit benefit corporation in 2010 dedicated to the betterment of public health care services in Orange County. During the year ended June 30, 2019, the Foundation was dissolved and all assets were transferred to CalOptima.

2020 and 2019 Financial Highlights

As of June 30, 2020 and 2019, total assets and deferred outflows of resources were approximately $2,256.8 million and $1,957.2 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $1,025.1 and $935.5 million, respectively.

Net position increased by approximately $89.6 million, or 9.6 percent, during fiscal year 2020 and increased by approximately $171.1 million, or 22.4 percent, during fiscal year 2019, including the transfer of Foundation assets of approximately $2.9 million.

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

Financial Position	2020	2019	Change from 2019 Amount	Change from 2019 Percentage
ASSETS				
Current assets	$ 1,556,053	$ 1,279,064	$ 276,989	21.7%
Board-designated assets and restricted cash	642,383	620,445	21,938	3.5%
Capital assets, net	46,655	46,625	30	0.1%
Total assets	2,245,091	1,946,134	298,957	15.4%
DEFERRED OUTFLOWS OF RESOURCES	11,661	11,090	571	5.1%
Total assets and deferred outflows of resources	$ 2,256,752	$ 1,957,224	$ 299,528	15.3%
LIABILITIES				
Current liabilities	$ 1,171,997	$ 965,968	$ 206,029	21.3%
Other liabilities	52,947	48,307	4,640	9.6%
Total liabilities	1,224,944	1,014,275	210,669	20.8%
DEFERRED INFLOWS OF RESOURCES	6,677	7,407	(730)	-9.9%
NET POSITION				
Net investment in capital assets	46,494	46,580	(86)	-0.2%
Restricted by legislative authority	100,574	84,930	15,644	18.4%
Unrestricted	878,064	804,032	74,032	9.2%
Total net position	1,025,132	935,542	89,590	9.6%
Total liabilities, deferred inflows of resources and net position	$ 2,256,753	$ 1,957,224	$ 299,529	15.3%

Current assets increased $277.0 million from $1,279.1 million in 2019 to $1,556.1 million in 2020, primarily in cash and premium receivables. Cash increased $165.9 million due to delays in the submission, processing, and reimbursement of medical claims during the novel coronavirus ("COVID-19") pandemic. The increase in premium receivables is primarily due to unpaid Managed Care Organization (MCO) tax. Current liabilities increased $206.0 million from $966.0 million in 2019 to $1,171.0 million in 2020, primarily due to an increase in payables due to the State of California (the "State") for to the Gross Medical Expense (GME) and Coordinated Care Initiative (CCI) risk corridors. The GME risk corridor was enacted on June 29, 2020, through the Fiscal Year 2020-21 State Budget.

2020 and 2019 Financial Highlights (continued)

Board-designated assets and restricted cash increased by $.022 million and $81.9 million in fiscal years 2020 and 2019, respectively. In fiscal year 2019, in addition to the existing Board-designated reserve, the Board of Directors designated a $60 million funding initiative for homeless health.

The Board of Directors' policy is to augment the rest of Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months of premium revenue to meet future contingencies. CalOptima's reserve level of tier one and two investment portfolios as of June 30, 2020, is at 1.96 times of monthly average premium revenue.

CalOptima is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975.

2019 and 2018 Financial Highlights

As of June 30, 2019 and 2018, total assets and deferred outflows of resources were approximately $1,957.2 million and $1,879.1 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $935.5 and $764.5 million, respectively.

Net position increased by approximately $171.1 million, or 22.4 percent, during fiscal year 2019, including the transfer of Foundation assets of approximately $2.9 million, and increased by approximately $45.8 million, or 6.4 percent, during fiscal year 2018.

2019 and 2018 Financial Highlights (continued)

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

Financial Position	2019	2018	Change from 2018 Amount	Change from 2018 Percentage
ASSETS				
Current assets	$ 1,279,064	$ 1,278,680	$ 384	0.0%
Board-designated assets and restricted cash	620,445	538,548	81,897	15.2%
Capital assets, net	46,625	50,758	(4,133)	-8.1%
Total assets	1,946,134	1,867,986	78,148	4.2%
DEFERRED OUTFLOWS OF RESOURCES	11,090	11,133	(43)	-0.4%
Total assets and deferred outflows of resources	$ 1,957,224	$ 1,879,119	$ 78,105	4.2%
LIABILITIES				
Current liabilities	$ 965,968	$ 1,061,545	$ (95,577)	-9.0%
Other liabilities	48,307	49,766	(1,459)	-2.9%
Total liabilities	1,014,275	1,111,311	(97,036)	-8.7%
DEFERRED INFLOWS OF RESOURCES	7,407	3,329	4,078	122.5%
NET POSITION				
Net investment in capital assets	46,580	50,637	(4,057)	-8.0%
Restricted by legislative authority	84,930	89,037	(4,107)	-4.6%
Unrestricted	804,032	624,805	179,227	28.7%
Total net position	935,542	764,479	171,063	22.4%
Total liabilities, deferred inflows of resources and net position	$ 1,957,224	$ 1,879,119	$ 78,105	4.2%

Current assets increased $0.4 million from $1,278.7 million in 2018 to $1,279.1 million in 2019. Current liabilities decreased $95.6 million from $1,061.5 million in 2018 to $966.0 million in 2019. The decrease is mostly due to a remittance back to the California DHCS for the Medi-Cal expansion medical loss ratio ("MLR") reconciliation for fiscal year 2014 through 2016 and recognition of previously unearned revenue.

Board-designated assets and restricted cash increased by $81.9 million and $3.1 million in fiscal years 2019 and 2018, respectively. In fiscal year 2019, in addition to the existing Board-designated reserve, the Board of Directors designated a $60 million funding initiative for homeless health.

The Board of Directors' policy is to augment the rest of Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months of premium revenue to meet future contingencies. CalOptima's reserve level of tier one and two investment portfolios as of June 30, 2019, is at 1.98 times of monthly average premium revenue.

CalOptima is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975.

2020 and 2019 Results of Operations

CalOptima's fiscal year 2020 operations and non-operating revenues resulted in a $89.6 million increase in net position, $81.5 million less compared to a $171.1 million increase in fiscal year 2019. The following table reflects the changes in revenues and expenses for 2020 compared to 2019:

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

Results of Operations	2020	2019	Change from 2019 Amount	Change from 2019 Percentage
PREMIUM REVENUES	$ 3,833,145	$ 3,474,634	$ 358,511	10.3%
Total operating revenues	3,833,145	3,474,634	358,511	10.3%
MEDICAL EXPENSES	3,644,419	3,216,673	427,746	13.3%
ADMINISTRATIVE EXPENSES	142,142	130,574	11,568	8.9%
Total operating expenses	3,786,561	3,347,247	439,314	13.1%
OPERATING INCOME	46,584	127,387	(80,803)	-63.4%
NONOPERATING REVENUES AND EXPENSES	43,004	43,676	(672)	-1.5%
Increase in net position	89,588	171,063	(81,475)	-47.6%
NET POSITION, beginning of year	935,543	764,480	171,063	22.4%
NET POSITION, end of year	$ 1,025,131	$ 935,543	$ 89,588	9.6%

2020 and 2019 Operating Revenues

The increase in operating revenues of $358.5 million in fiscal year 2020 is primarily attributable to the addition of the new Whole Child Model (WCM) program which began on July 1, 2019, Hospital Directed Payments, Intergovernmental Transfers ("IGT"), and expansion of Proposition 56 (The Research and Prevention Tobacco Tax Act of 2016). The increase in revenue is offset by a 1.5 percent GME rate reduction and risk corridor for the period of July 1, 2019 through December 31, 2020 (i.e., Bridge Period), that is approved in State's Fiscal Year (FY) 2020-21 budget and overall lower enrollment in FY 2020 compared to FY 2019.

2020 and 2019 Medical Expenses

Overall medical expenses increased by $427.7 million or 13 percent in fiscal year 2020, totaling $3,644.4 million, compared to $3,216.7 million in fiscal year 2019. CalOptima's MLR, or medical expenses as a percentage of operating revenues, increased 2.5 percent to 95.1 percent in 2020 from 92.6 percent in fiscal year 2019.

2020 and 2019 Medical Expenses (continued)

Medi-Cal provider capitation, comprised of capitation payments to CalOptima's contracted health networks, increased by 3.5 percent from fiscal year 2019 to fiscal year 2020. Capitated member enrollment accounted for approximately 74.9 percent of CalOptima's enrollment, averaging 542,204 members during fiscal year 2020, and 76.3 percent of CalOptima's enrollment, averaging 573,455 members during fiscal year 2019. Included in the capitated environment are 175,704 or 32.4 percent and 192,011 or 33.5 percent members in a shared risk network for fiscal years 2020 and 2019, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Medi-Cal provider capitation expenses totaled $1,133.1 million in fiscal year 2020, compared to $1,094.3 million in fiscal year 2019. The increase reflects additional capitation expenses relating to WCM and expansion of Proposition 56 program which authorizes additional supplemental payments to impacted physician services compared to fiscal year 2019.

Medi-Cal claims expense to providers and facilities, including Long-Term Care ("LTC") services increased by 5.3 percent from fiscal year 2019 to fiscal year 2020 primarily driven by increase in price and utilization trends.

Prescription drug costs increased by 24.3 percent in fiscal year 2020, compared to fiscal year 2019. Results from fiscal year 2020 reflects additional prescription drugs utilization from new WCM program.

In addition to items mentioned above, total Quality Assurance Fee ("QAF") payments received and passed through to hospitals decreased from $297.4 million to $154.6 million from fiscal year 2019 to fiscal year 2020. These receipts and payments are not included in the statements of revenues, expenses, and changes in net position.

2020 and 2019 Administrative Expenses

Total administrative expenses were $142.1 million in 2020 compared to $130.6 million in 2019. Overall administrative expenses increased by 8.9 percent or $11.6 million, corresponding to higher salaries and benefits due additional staffing and California Public Employees Retirement Systems ("CalPERS") expense, along with inflation increases in other expense categories. During fiscal years 2020 and 2019, respectively, CalOptima's administrative expenses remained at 3.8 percent of total operating revenues.

2019 and 2018 Results of Operations

CalOptima's fiscal year 2019 operations and nonoperating revenues resulted in a $171.1 million increase in net position, $125.2 million more compared to a $45.8 million decrease in fiscal year 2018. The following table reflects the changes in revenues and expenses for 2019 compared to 2018:

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

Results of Operations	2019	2018	Change from 2018 Amount	Change from 2018 Percentage
CAPITATION REVENUES	$ 3,474,634	$ 3,445,699	$ 28,935	0.8%
Total operating revenues	3,474,634	3,445,699	28,935	0.8%
MEDICAL EXPENSES	3,216,673	3,291,712	(75,039)	-2.3%
ADMINISTRATIVE EXPENSES	130,574	131,847	(1,273)	-1.0%
Total operating expenses	3,347,247	3,423,559	(76,312)	-2.2%
OPERATING INCOME	127,387	22,140	105,247	475.4%
NONOPERATING REVENUES AND EXPENSES	43,676	23,700	19,976	84.3%
Increase in net position	171,063	45,840	125,223	273.2%
NET POSITION, beginning of year	764,480	718,640	45,840	6.4%
NET POSITION, end of year	$ 935,543	$ 764,480	$ 171,063	22.4%

2019 and 2018 Operating Revenues

The increase in operating revenues of $28.9 million in fiscal year 2019 is attributable to an overall capitation rate increase, Intergovernmental Transfers ("IGT"), expansion of Proposition 56, recognition of net increase to Coordinated Care Initiative ("CCI") revenue after an update made to enrollment logic (offset by decreased blended paid rate from DHCS). Overall lower enrollment in fiscal year 2019 compared to fiscal 2018 offsets part of the revenue increase.

2019 and 2018 Medical Expenses

Overall medical expenses decreased by $75.0 million or 2.3 percent in fiscal year 2019, totaling $3,216.7 million, compared to $3,291.7 million in fiscal year 2018. CalOptima's MLR, or medical expenses as a percentage of operating revenues, decreased 2.9 percent from 95.5 to 92.6 percent in fiscal year 2018 to 2019.

2019 and 2018 Medical Expenses (continued)

Medi-Cal provider capitation, comprised of capitation payments to CalOptima's contracted health networks, increased by 2.4 percent from fiscal year 2018 to fiscal year 2019. Capitated member enrollment accounted for approximately 76.3 percent of CalOptima's enrollment, averaging 573,455 members during fiscal year 2019, and 76.4 percent of CalOptima's enrollment, averaging 590,204 members during fiscal year 2018. Included in the capitated environment are 192,011 or 33.5 percent and 198,508 or 33.6 percent members in a shared risk network for fiscal years 2019 and 2018, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Medi-Cal provider capitation expenses totaled $1,094.3 million in fiscal year 2019, compared to $1,068.4 million in fiscal year 2018. The increase reflects additional capitation expenses relating to Proposition 56 compared to 2018.

Medi-Cal claims expense to providers and facilities, including Long-Term Care ("LTC") services decreased by 8.3 percent from fiscal year 2018 to fiscal year 2019. This decrease is attributable to lower enrollment and the discontinuation of In-Home Supportive Services ("IHSS") services beginning January 2018.

Prescription drugs costs increased by 0.8 percent in fiscal year 2019, compared to fiscal year 2018. Results from fiscal year 2019 reflects an increase in prescription drug prices.

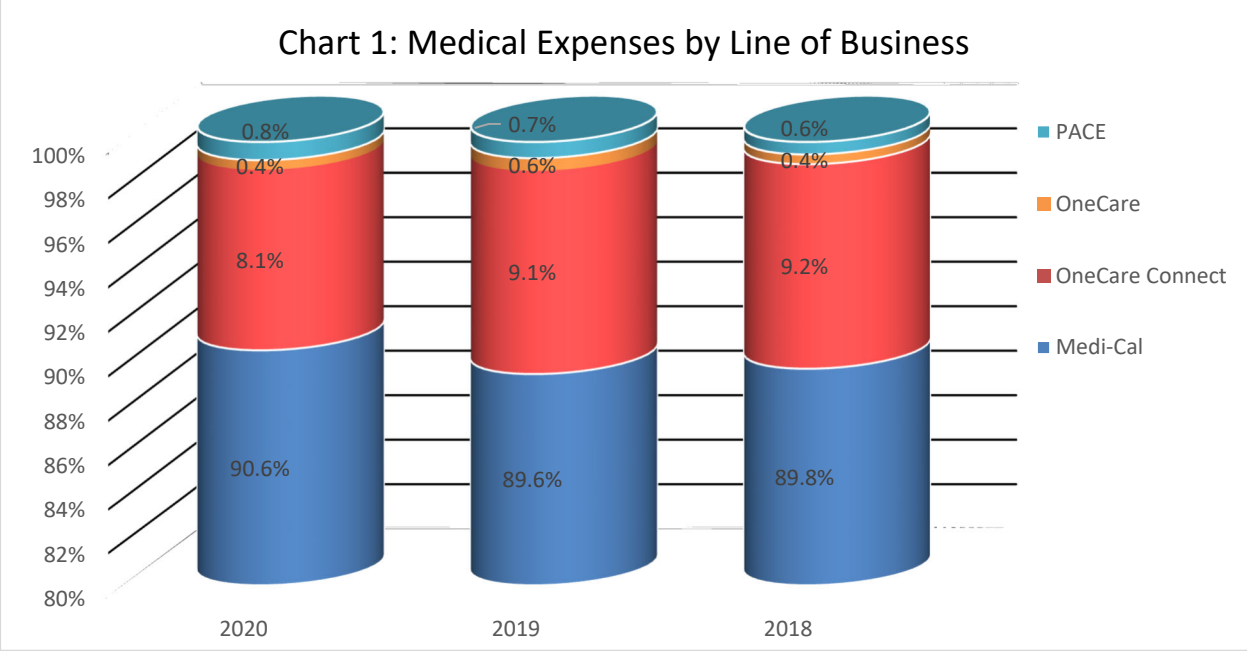
In addition to items mentioned above, total Quality Assurance Fee ("QAF") payments received and passed through to hospitals decreased from $307.8 million to $297.4 million from fiscal year 2018 to fiscal year 2019. These receipts and payments are not included in the statements of revenues, expenses, and changes in net position.

2019 and 2018 Administrative Expenses

Total administrative expenses were $130.6 million in 2019 compared to $131.8 million in 2018. Overall administrative expenses decreased by 1.0 percent or $1.3 million, corresponding to lower salaries and benefits due to the effect of a non-recurring CalPERS discount rate reduction from 7.7 percent to 7.2 percent, with offsetting inflation increases in other expense categories. During fiscal years 2019 and 2018, respectively, CalOptima's administrative expenses remained at 3.8 percent of total operating revenues.

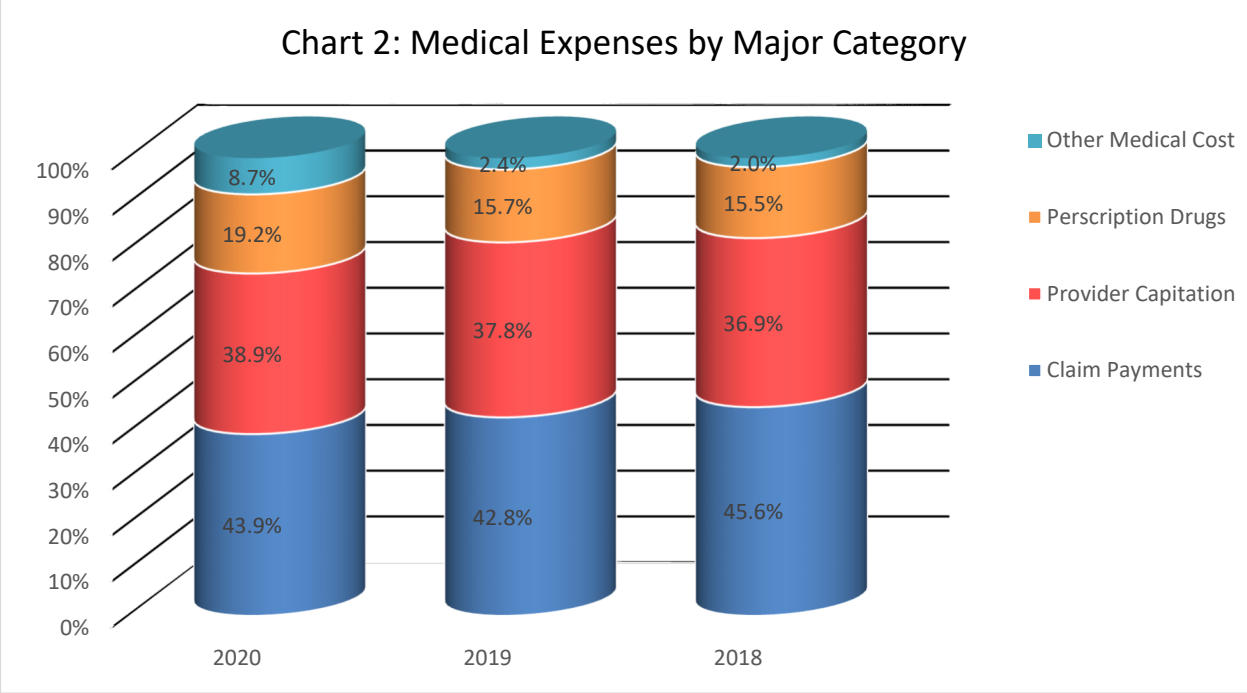
2020, 2019, and 2018 Medical Expenses by Line of Business

Below is a comparison chart of total medical expenses by line of business and their respective percentages of the overall medical expenditures by fiscal year.



2020, 2019, and 2018 Medical Expenses by Major Category

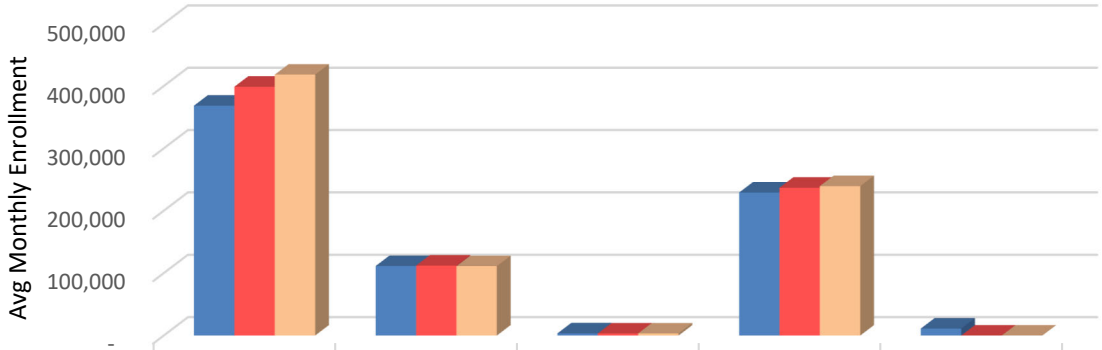
Below is a comparison chart of medical expenses by major category and their respective percentages of the overall medical expenditures by fiscal year.



2020, 2019, and 2018 Enrollment

During fiscal year 2020, CalOptima served an average of 724,049 Medi-Cal members per month compared to an average of 751,409 members per month in 2019 and 772,511 members per month in 2018. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2020, 2019, and 2018:

Chart 3: Medi-Cal Membership by Aid Category
(Shown as Average Member Months)



	TANF	Disabled/Aged	LTC	MCE	WCM
2020	368,614	111,496	3,493	229,196	11,250
2019	398,951	112,089	3,402	236,967	-
2018	418,378	111,158	3,440	239,535	-

Significant aid categories are defined as follows:

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

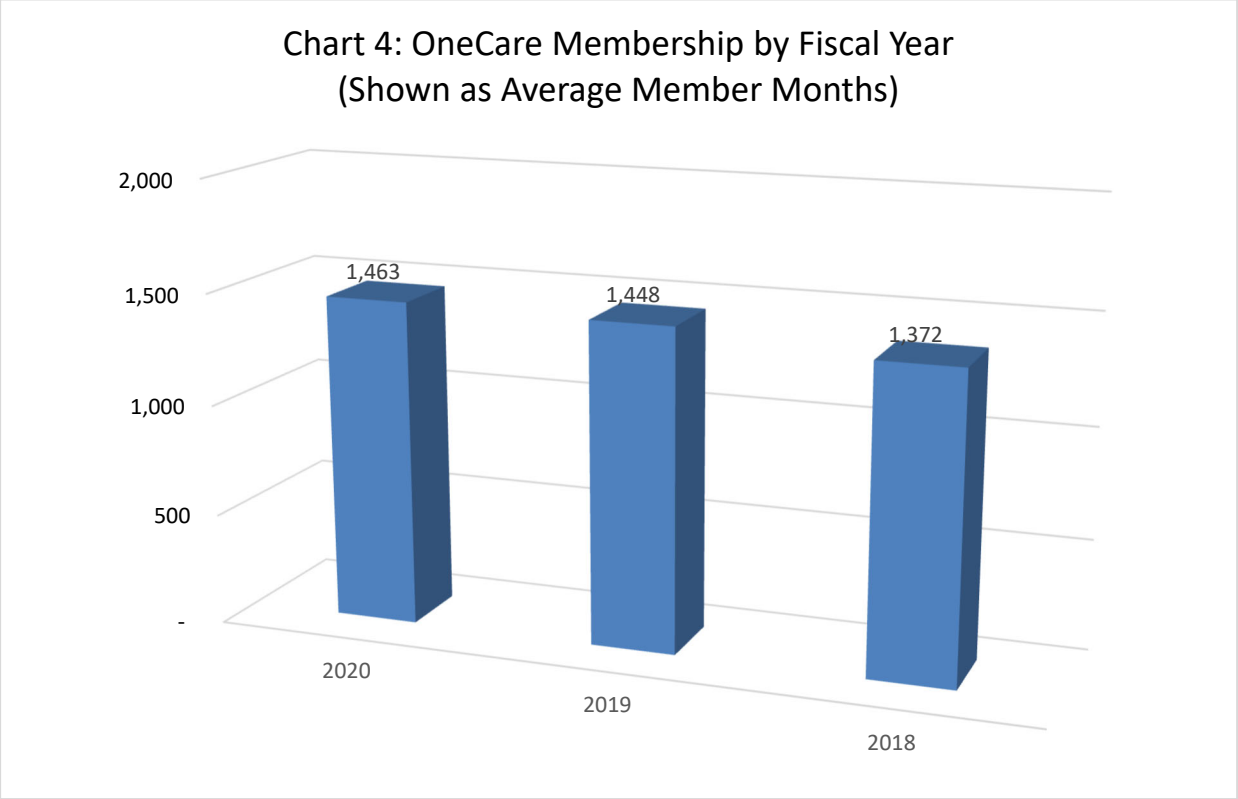
Disabled and Aged includes individuals who have met the criteria for disability set by the Social Security Administration, and individuals of 65 years of age and older who receive supplemental security income ("SSI") checks, or are medically needy, or have an income of 100 percent or less of the federal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

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

2020, 2019, and 2018 Enrollment (continued)

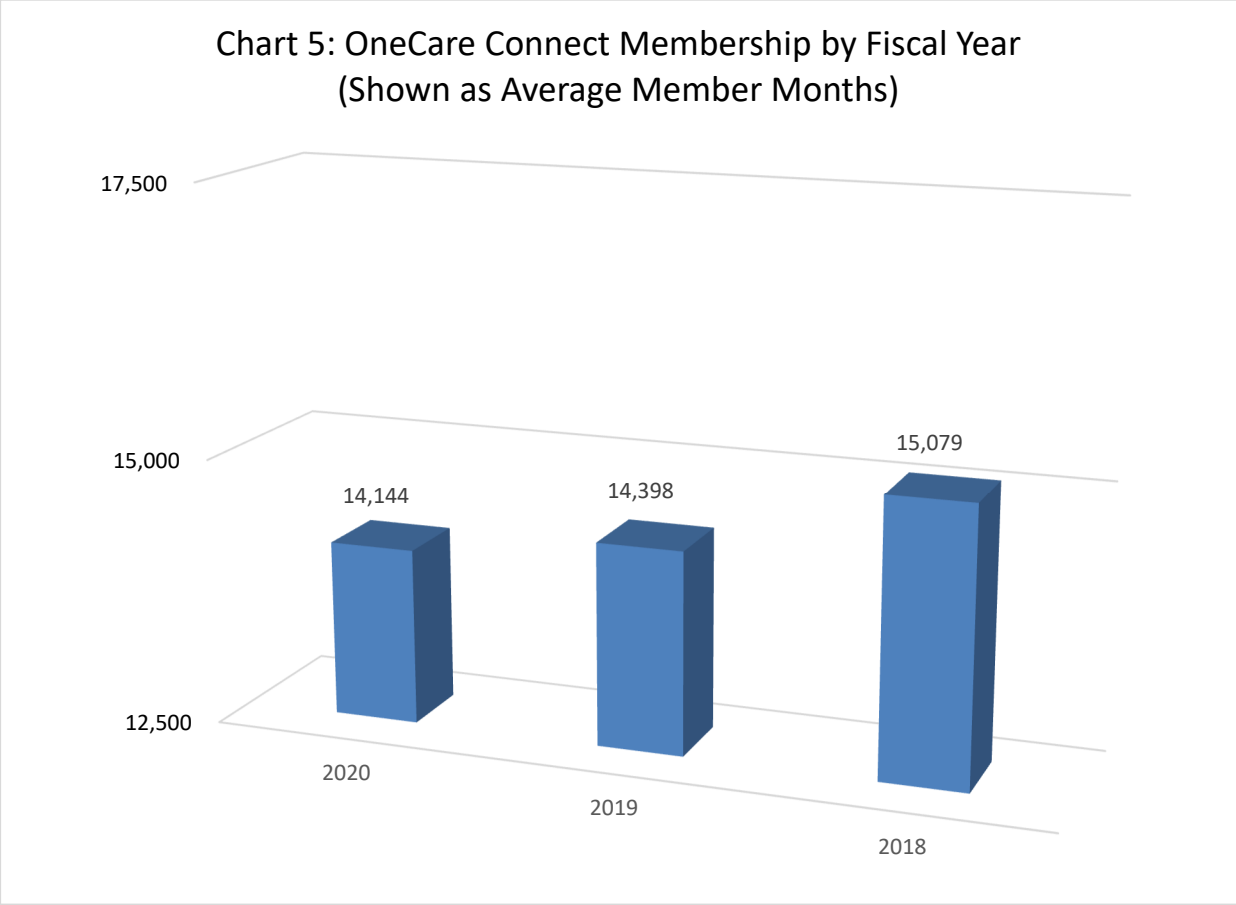
Medi-Cal Expansion ("MCE") program includes adults without children, ages 19–64, qualified based upon income, as required by the Patient Protection and Affordable Care Act ("ACA").

OneCare was introduced in fiscal year 2006 to service the unique Medicare Advantage Special Needs Plan. It provides a full range of health care services to average member months of 1,463, 1,448, and 1,372 for the years ended June 30, 2020, 2019, and 2018, respectively. Members are eligible for both the Medicare and Medi-Cal programs. The chart below displays the average member months for the past three years.



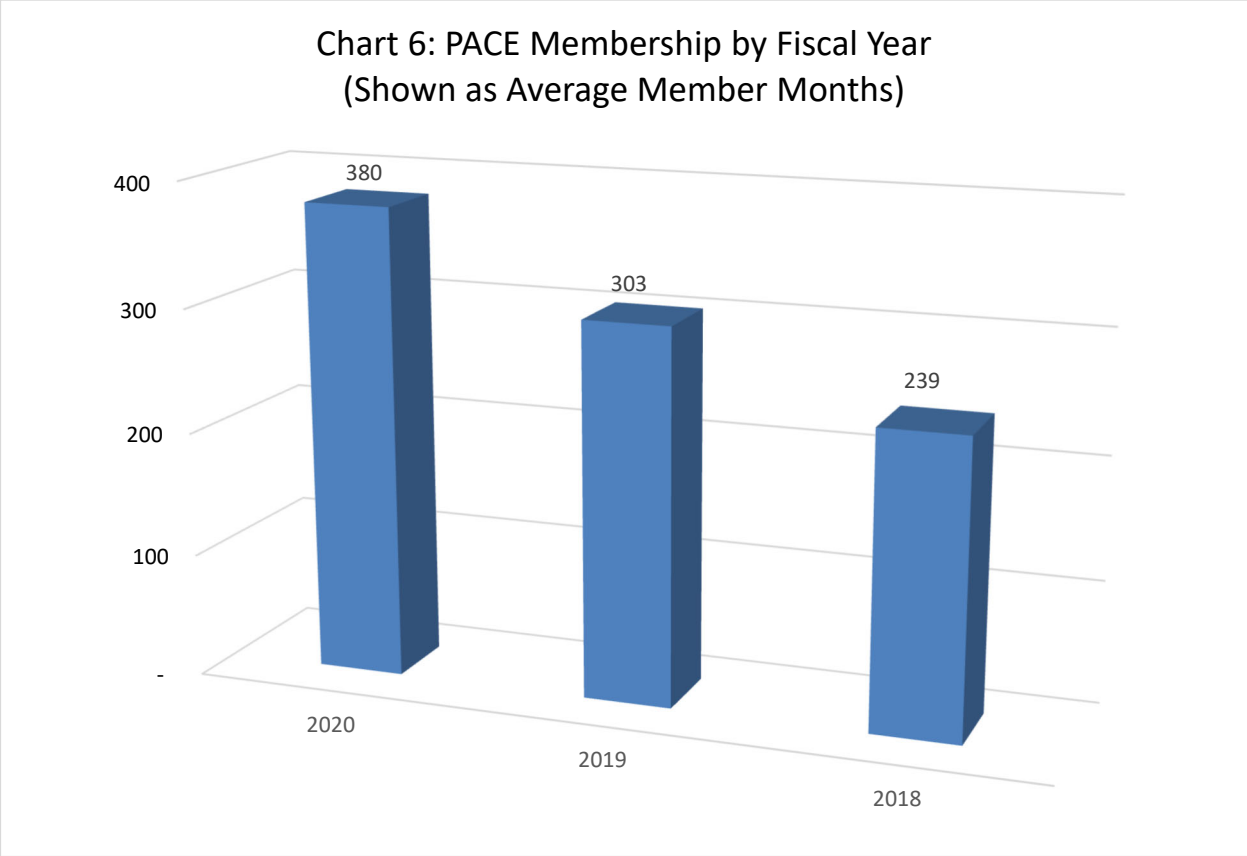
2020, 2019, and 2018 Enrollment (continued)

CalOptima launched OneCare Connect ("OCC") program to serve dual eligible members in Orange County on July 1, 2015. This program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. The average member months of 14,144, 14,398, and 15,079 for the years ended June 30, 2020, 2019, and 2018, respectively. The chart below displays the average member months for the past three years.



2020, 2019, and 2018 Enrollment (continued)

PACE started operations in October 2013. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community. The average member months of 380, 303, and 239 for the years ended June 30, 2020, 2019, and 2018, respectively. The chart below displays the average member months for the past three years.



Economic Factors and the State's Fiscal Year 2020-21 Budget

On March 4, 2020, the Governor proclaimed a state of emergency for the COVID-19 outbreak. The emergency has led to an economic recession from massive job losses, business closures and increased costs to state and local governments.

On June 29, 2020, Governor Gavin Newsom signed the Fiscal Year (FY) 2020-21 state budget. The budget addressed a $54.3 billion budget gap primarily resulting from the COVID-19 pandemic, while protecting public health and education and promoting government efficiencies. State actions to address long-term structural deficits and reduce spending, along with federal assistance will directly impact the state's path to economic recovery.

General Fund spending in the budget package was $133.9 billion, a decrease of $13.0 billion or 9 percent from FY 2019-20. The budget included $23.6 billion in General Fund spending for the Medi-Cal program. It assumed that statewide enrollment would peak at 14.5 million by July 2020, resulting in a 9.2 percent year-over-year increase in Medi-Cal enrollment. Major Medi-Cal program changes adopted in the budget include:

- Reductions to managed care plans: Acuity, efficiency, and cost containment adjustments to capitation rates beginning January 1, 2021, and a 1.5 percent rate reduction and implementation of a risk corridor calculation for the period of July 1, 2019 through December 31, 2020 (i.e., Bridge Period).

- Expansion of eligibility to aged, blind and disabled individuals with incomes between 123 percent and 138 percent FPL.

- Expansion of the Medi-Cal benefit for pregnant individuals with a maternal mental health condition.

The budget projected $137.7 billion in General Fund revenues and transfers in FY 2020-21, an increase of $94 million or 0.1 percent compared to last fiscal year. The three largest General Fund taxes (i.e., personal income tax, sales and use tax, corporation tax) were projected to decrease by 15 percent. The State is projected to end FY 2020-21 with $11.4 billion in total reserves.

Coronavirus pandemic – On March 4, 2020, the Governor proclaimed a state of emergency for the novel coronavirus outbreak. The emergency has led to an economic recession from massive job losses, business closures, and increased costs to state and local governments. As of June 2020, the State projected a budget shortfall of $54.3 billion by the end of June 2021. State actions to address long-term structural deficits and reduce spending, along with federal assistance will directly impact the state's path to economic recovery. The FY 2020-21 state budget provisions included a 1.5 percent rate reduction to Medi-Cal managed care plans and implemented a risk corridor calculation for the period of July 1, 2019 through December 31, 2020 (i.e., 18-month bridge period).

Economic Factors and the State's Fiscal Year 2020-21 Budget (continued)

DHCS annual audit – DHCS conducted its annual audit of CalOptima's Medi-Cal program and the Medicaid-based services for the OneCare Connect program in late January and early February 2020. The audit review period was from February 2019 through January 2020. DHCS' draft audit report included findings in the areas of Access and Availability of Care and Member Rights. No findings were reported for the areas of State Supported Services or the OneCare Connect program. In July 2020, CalOptima notified DHCS of our acceptance of the findings in the draft audit report. CalOptima anticipates receipt of the final audit report and a request for a corrective action plan in August 2020.

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

MOSSADAMS

Report of Independent Auditors

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

Report on Financial Statements

We have audited the accompanying statements of net position of Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima (a discrete component unit of the County of Orange, California) ("CalOptima"), as of June 30, 2020 and 2019, and the related statements of revenues, expenses, and changes in net position and cash flows for the years ended June 30, 2020 and 2019, and the related notes to the financial statements, which collectively comprise CalOptima's basic financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of CalOptima as of June 30, 2020 and 2019, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

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

Moss Adams LLP

Irvine, California
September 23, 2020

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

	June 30, 2020	June 30, 2019
CURRENT ASSETS		
Cash and cash equivalents	$ 378,797,374	$ 347,627,785
Investments	724,186,314	573,706,297
Premiums due from the State of California and CMS	403,300,443	302,964,503
Prepaid expenses and other	49,768,791	54,765,005
Total current assets	1,556,052,922	1,279,063,590
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH		
Cash and cash equivalents	59,979,769	72,711,832
Investments	582,103,037	547,433,576
Restricted deposit	300,000	300,000
	642,382,806	620,445,408
CAPITAL ASSETS, NET	46,654,576	46,624,892
Total assets	2,245,090,304	1,946,133,890
DEFERRED OUTFLOWS OF RESOURCES		
Net pension	10,388,070	10,534,449
Other postemployment benefit	1,273,000	556,000
Total deferred outflows of resources	11,661,070	11,090,449
Total assets and deferred outflows of resources	$ 2,256,751,374	$ 1,957,224,339

See accompanying notes to the financial statements.

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

	June 30, 2020	June 30, 2019
CURRENT LIABILITIES		
Medical claims liability and capitation payable		
Medical claims liability	$ 302,058,508	$ 287,288,604
Provider capitation and withholds	142,981,028	108,903,139
Accrued reinsurance costs to providers	4,843,302	3,209,901
Due to the State of California and CMS	677,497,633	496,690,411
Unearned revenue	22,693,499	50,147,341
	1,150,073,970	946,239,396
Accounts payable and other	8,300,077	8,658,894
Accrued payroll and employee benefits and other	13,621,877	11,069,278
Total current liabilities	1,171,995,924	965,967,568
POSTEMPLOYMENT HEALTH CARE PLAN	25,824,000	24,705,000
NET PENSION LIABILITY	27,122,873	23,602,064
Total liabilities	1,224,942,797	1,014,274,632
DEFERRED INFLOWS OF RESOURCES		
Net pension	4,235,272	4,903,835
Other postemployment benefit	2,442,000	2,503,000
Total deferred inflows of resources	6,677,272	7,406,835
NET POSITION		
Net investment in capital assets	46,493,718	46,580,380
Restricted by legislative authority	100,573,922	84,930,126
Unrestricted	878,063,665	804,032,366
Total net position	1,025,131,305	935,542,872
Total liabilities, deferred inflows of resources, and net position	$ 2,256,751,374	$ 1,957,224,339

See accompanying notes to the financial statements.

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

Statements of Revenues, Expenses, and Changes in Net Position

	Years Ended June 30,	
	2020	2019
REVENUES		
Premium revenues	$ 3,833,145,186	$ 3,474,634,375
Total operating revenues	3,833,145,186	3,474,634,375
OPERATING EXPENSES		
Medical expenses		
Claims expense to providers and facilities	1,354,894,408	1,287,230,443
Provider capitation	1,133,100,408	1,094,332,595
Prescription drugs	553,908,228	445,721,355
OneCare Connect	295,701,392	293,947,460
Other medical	261,321,998	53,871,235
PACE	29,648,249	23,297,732
OneCare	15,843,762	18,272,703
Total medical expenses	3,644,418,445	3,216,673,523
Administrative expenses		
Salaries, wages, and employee benefits	92,838,076	84,618,793
Supplies, occupancy, insurance, and other	26,463,554	22,975,749
Purchased services	12,950,542	12,584,719
Depreciation	6,208,308	7,226,723
Professional fees	3,681,376	3,167,619
Total administrative expenses	142,141,856	130,573,603
Total operating expenses	3,786,560,301	3,347,247,126
OPERATING INCOME	46,584,885	127,387,249
NON-OPERATING REVENUES		
Net investment income and other	43,003,548	43,675,873
Total non-operating revenues	43,003,548	43,675,873
Increase in net position	89,588,433	171,063,122
NET POSITION, beginning of year	935,542,872	764,479,750
NET POSITION, end of year	$ 1,025,131,305	$ 935,542,872

See accompanying notes to the financial statements.

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

	Years Ended June 30, 2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	$ 3,886,162,626	$ 3,335,206,230
Payments to providers and facilities	(3,593,937,251)	(3,180,342,695)
Payments to vendors	(37,857,991)	(61,188,697)
Payments to employees	(86,945,852)	(81,658,054)
Net cash provided by operating activities	167,421,532	12,016,784
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(6,838,076)	(3,692,776)
Net cash used in capital and related financing activities	(6,838,076)	(3,692,776)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment income received	47,645,156	49,387,239
Purchases of securities	(6,861,181,847)	(13,023,305,579)
Sales of securities	6,684,122,824	12,942,289,130
Net cash used in investing activities	(129,413,867)	(31,629,210)
Net change in cash and cash equivalents	31,169,589	(23,305,202)
CASH AND CASH EQUIVALENTS, beginning of year	347,627,785	370,932,987
CASH AND CASH EQUIVALENTS, end of year	$ 378,797,374	$ 347,627,785
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 46,584,885	$ 127,387,249
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Depreciation	6,808,392	7,826,138
Changes in assets and liabilities		
Premiums due from the State of California and CMS	(100,335,940)	(6,592,863)
Prepaid expenses and other	4,996,214	(23,688,282)
Medical claims liability	14,769,904	24,231,167
Provider capitation and withholds	34,077,889	12,354,248
Accrued reinsurance costs to providers	1,633,401	(254,587)
Due to the State of California and CMS	180,807,222	(70,425,615)
Unearned revenue	(27,453,842)	(62,409,667)
Accounts payable and other	(358,817)	628,257
Accrued payroll and employee benefits and other	2,552,599	199,439
Postemployment health care plan	341,000	346,000
Net pension liability	2,998,625	2,415,300
Net cash provided by operating activities	$ 167,421,532	$ 12,016,784
SUPPLEMENTAL SCHEDULE OF NON-CASH OPERATING AND INVESTING ACTIVITIES		
Change in unrealized appreciation on investments	$ 14,075,788	$ 4,652,813

See accompanying notes to the financial statements.

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Note 1 – Organization

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

As a COHS, CalOptima maintains an exclusive contract with the State of California (the "State") DHCS to arrange for the provision of health care services to Orange County's Medi-Cal beneficiaries. Orange County had approximately 743,000 and 744,000 Medi-Cal beneficiaries for the years ended June 30, 2020 and 2019, respectively. CalOptima also offers OneCare, a Medicare Advantage Special Needs Plan, via a contract with the Centers for Medicare & Medicaid Services ("CMS"). OneCare served approximately 1,500 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2020 and 2019. In January 2016, CalOptima began offering the OneCare Connect Cal MediConnect Plan ("OCC"), a Medicare-Medicaid Plan, via a contract with CMS and DHCS. OCC served approximately 14,000 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2020 and 2019. In January 2016, CalOptima began transferring subscribers from OneCare to the OneCare Connect Cal MediConnect Plan. CalOptima also contracts with the California Department of Aging to provide case management of social and health care services to approximately 500 Medi-Cal eligible seniors under the State's Multipurpose Senior Services Program ("MSSP"). PACE provides services to 55 years of age or older members who reside in the PACE service area and meet California nursing facility level of care requirements. The program receives Medicare and Medi-Cal funding.

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

CalOptima is Knox-Keene licensed for purposes of its Medicare programs and is subject to certain provisions of the Knox- Keene Health Care Service Plan Act of 1975 (the "Act") to the extent incorporated by reference into CalOptima's contract with DHCS. As such, CalOptima is subject to the regulatory requirements of the Department of Managed Health Care ("DMHC") under Section 1300, Title 28 of the California Administrative Code of Regulations, including minimum requirements of Tangible Net Equity ("TNE"), which CalOptima exceeded as of June 30, 2020 and 2019.

CalOptima Foundation (the "Foundation") was formed as a not-for-profit benefit corporation in 2010 dedicated to the betterment of public health care services in Orange County. During the year ended June 30, 2019, the Foundation was dissolved and all assets were transferred to CalOptima.

Note 2 – Summary of Significant Accounting Policies

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

Principle of consolidation – The financial statements include the accounts of CalOptima and the Foundation (collectively referred to herein as the "Organization"). During the year ended June 30, 2019, the Foundation was dissolved (see Note 1).

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

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

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

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

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

Board-designated assets and restricted cash – Board-designated assets include amounts designated by the Board of Directors for the establishment of certain reserve funds for contingencies at a desired level between 1.4 and 2 months of premium revenues and amounts designated by the Board of Directors for CalOptima's homeless health initiative (see Note 3). Restricted cash represents a $300,000 restricted deposit required by CalOptima as part of the Act (see Note 9).

Note 2 – Summary of Significant Accounting Policies (continued)

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

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

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

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

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

Note 2 – Summary of Significant Accounting Policies (continued)

Provider capitation and withholds – CalOptima has provider services agreements with several health networks in Orange County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. CalOptima withholds amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. CalOptima also records a liability related to quality incentive payments and risk-share provisions. The quality incentive liability is estimated based on member months and rates agreed upon by the Board of Directors. For the risk-share provision liability, management allocates surpluses or deficits, multiplied by a contractual rate, with the shared-risk groups. Estimated amounts due to health networks pertaining to risk-share provisions were approximately $24,437,000 and $40,167,000 as of June 30, 2020 and 2019, respectively, and are included in provider capitation and withholds on the statements of net position. During the years ended June 30, 2020 and 2019, CalOptima incurred approximately $1,279,859,000 and $1,243,391,000, respectively, of capitation expense relating to health care services provided by health networks. Capitation expense is included in the provider capitation, OneCare Connect, and OneCare line items in the statements of revenues, expenses, and changes in net position. Estimated amounts due to health networks as of June 30, 2020 and 2019, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions were approximately $142,981,000 and $108,903,000, respectively.

Premium deficiency reserves – CalOptima performs periodic analyses of its expected future health care costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is not included in the calculation to estimate premium deficiency reserves. CalOptima's management determined that no premium deficiency reserves were necessary as of June 30, 2020 and 2019.

Accrued compensated absences – CalOptima's policy permits employees who are regularly scheduled to work more than 20 hours per week to accrue 18 days of paid time off (PTO) (23 days for exempt employees) based on their years of continuous service, with an additional week of accrual after three years of service and another after 10 years of service. In the event that available PTO is not used by the end of the benefit year, employees may carry unused time off into subsequent years, up to the maximum accrual amount equal to two (2) times the employee's annual accrual. If an employee reaches his or her maximum PTO accrual amount, the employee will stop accruing PTO. Accumulated PTO will be paid to the employees upon separation from service with CalOptima. All compensated absences are accrued and recorded in accordance with GASB Codification Section C60 and are included in accrued payroll and employee benefits.

Note 2 – Summary of Significant Accounting Policies (continued)

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

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

- *Restricted by legislative authority* – This component of net position consists of external constraints placed on net asset use by creditors (such as through debt covenants), grantors, contributors, or the law or regulations of other governments. It also pertains to constraints imposed by law or constitutional provisions or enabling legislation (see Note 9).

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

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

Revenue recognition and due to or from the State and CMS – Premium revenue is recognized in the period the members are eligible to receive health care services. Premium revenue is generally received from the State each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the State contract. As such, premium revenue includes an estimate for amounts receivable from or refundable to the State for these retrospective adjustments. These estimates are continually monitored and analyzed, with any adjustments recognized in the period when determined. OneCare premium revenue is generally received from CMS each month for the month of coverage. Premiums received in advance are recorded in unearned revenue on the statements of net position. Included in premium revenue are retroactive adjustments favorable to CalOptima in the amount of approximately $254,567,000 and $104,724,000 related to retroactive capitation rate adjustments and receipt of new information from DHCS during the years ended June 30, 2020 and 2019, respectively.

Note 2 – Summary of Significant Accounting Policies (continued)

The State pays CalOptima premium revenue retrospectively on an estimated basis each month. Premium revenue is recognized as revenue in the month the beneficiary is eligible for Medi-Cal services. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by DHCS and validated by the State. The State provides CalOptima the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of premium revenue for the respective month.

Effective with the enrollment of the Medi-Cal Expansion population per the ACA, CalOptima is subject to DHCS requirements to meet the minimum 85 percent medical loss ratio ("MLR") for this population. Specifically, CalOptima will be required to expend at least 85 percent of the Medi-Cal premium revenue received for this population on allowable medical expenses as defined by DHCS. In the event CalOptima expends less than the 85 percent requirement, CalOptima will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. CalOptima's contract with CMS and DHCS requires for CalOptima to perform and submit the MLR calculations for periods beginning July 1, 2017, to DHCS. During 2018, DHCS completed their reconciliation of the MLR calculation for fiscal years 2014 through 2016. Based on the results of the reconciliation, CalOptima paid back premium revenue of approximately $102,000,000 during the year ended June 30, 2019. CalOptima was notified in March 2020 that they would receive approximately $9,830,000 for the fiscal year 2017.

In April 2019, CalOptima was notified that CMS will be performing their own reconciliation of the MLR data. As of the date the financial statements were available to be issued, CMS had not yet completed their reconciliation. As of June 30, 2020 and 2019, approximately $135,390,000 and $125,563,000 was accrued, respectively. This liability is presented in the Due to State of California and CMS line item in the accompanying statements of net position.

Note 2 – Summary of Significant Accounting Policies (continued)

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

	Years Ended June 30,			
	2020		2019	
	Revenue	%	Revenue	%
Revenue				
Medi-Cal	$ 3,462,115,218	90.3%	$ 3,134,181,615	90.2%
OneCare	15,950,202	0.4%	20,613,604	0.6%
OneCare Connect	317,641,605	8.3%	292,428,409	8.4%
PACE	37,438,161	1.0%	27,410,747	0.8%
	$ 3,833,145,186	100.0%	$ 3,474,634,375	100.0%

	As of June 30,			
	2020		2019	
	Receivables	%	Receivables	%
Receivables				
Medi-Cal	$ 382,302,317	94.9%	$ 290,217,790	95.7%
OneCare	2,930,861	0.7%	-	0.0%
OneCare Connect	14,654,822	3.6%	10,638,887	3.5%
PACE	3,412,443	0.8%	2,107,826	0.8%
	$ 403,300,443	100.0%	$ 302,964,503	100.0%

Intergovernmental transfer – CalOptima entered into an agreement with DHCS and Governmental Funding Entities to receive an IGT through a capitation rate increase of approximately $128,932,000 and $124,714,000 during the years ended June 30, 2020 and 2019, respectively. Under the agreement, approximately $84,971,000 and $81,951,000 of the funds that were received from the IGT were passed through to Governmental Funding Entities and other contracted providers and organizations during the years ended June 30, 2020 and 2019, respectively. Under GASB, the amounts that will be passed through to Governmental Funding Entities are not reported in the statements of revenues, expenses, and changes in net position or the statements of net position. CalOptima accounts for the IGT transfer for CalOptima purposes as an exchange transaction requiring funds to be expended prior to revenue recognition. CalOptima retains a portion of the IGT, which must be used to enhance provider reimbursement rates and strengthen the delivery system. A retainer in the amount of approximately $22,267,000 and $45,565,000 as of June 30, 2020 and 2019, respectively, is included in unearned revenues in the statements of net position.

Note 2 – Summary of Significant Accounting Policies (continued)

Directed Payments – DHCS implemented a new hospital Directed Payment program with CalOptima. The program implements enhanced reimbursement to eligible and participating network hospitals for contracted services. This hospital Directed Payment program is broken into three types: 1) Private Hospital Directed Payment Program (PHDP), 2) Public Hospital Enhanced Payment Program (EDP), and 3) Public Hospital Quality Incentive Program (QIP). Under the Directed Payment program, approximately $195,528,000 and $0 of the funds that were received from DHCS were passed through to hospitals as requested by DHCS during the years ended June 30, 2020 and 2019, respectively. The receipts from DHCS are included in premium revenues, and the payments made to the hospitals are included in other medical expenses in the statements of net position.

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

The risk corridor provisions compare costs targeted in CalOptima's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to CalOptima or require CalOptima to refund to CMS a portion of the premiums CalOptima received. CalOptima estimates and recognizes an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date, as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. CalOptima records a receivable or payable at the contract level and classifies the amount as current or long-term in the accompanying statements of net position based on the timing of expected settlement. As of June 30, 2020 and 2019, the Part D payable balance was approximately $972,000 and $1,240,000, respectively, and the Part D receivable balance was approximately $31,628,000 and $23,148,000, respectively.

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

Note 2 – Summary of Significant Accounting Policies (continued)

Premium taxes – Effective July 1, 2016, Senate Bill X2-2 ("SB X2-2") *Managed Care Organization Tax* authorized DHCS to implement a Managed Care Organization provider tax subject to approval by the federal CMS. This approved tax structure is based on enrollment (total member months) between specified tiers that are assessed different tax rates. During fiscal year 2020, the MCO tax was extended with an effective date of January 1, 2020. Using the approved structure, each MCO's total tax liability for years ended June 30, 2020 and 2019, were calculated. CalOptima recognized premium tax expense of approximately $74,845,000 and $136,649,000 as a reduction of premium revenues in the statements of revenue, expenses, and change in net position for the years ended June 30, 2020 and 2019, respectively. At June 30, 2020 and 2019, CalOptima's MCO tax liability amounted to approximately $66,535,000 and $34,002,000, respectively, and are included in Due to the State of California and CMS on the accompanying statements of net position.

Risk corridors – During the year ended June 30, 2020, CalOptima's contract with DHCS is subject to a risk corridor for the Managed Long-Term Services and Supports program for the period of July 1, 2015 through June 30, 2017. Additionally, the State's fiscal year 2021-21 enacted budget includes a Gross Medical Expense (GME) risk corridor for the period of July 1, 2019 to December 31, 2020. Both risk corridors are subject to certain thresholds of medical expenses compared to premium revenues. Variances exceeding the thresholds may require CalOptima to refund premium revenues back to DHCS. CalOptima estimates and recognizes an adjustment to premium revenues based on actual membership and capitation rates in effect. As of June 30, 2020, CalOptima has recognized a reduction of premium revenues and a liability of approximately $124,212,000 related to the risk corridors. There was no such liability recognized as of June 30, 2019.

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

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

Recent accounting pronouncements – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities*. The principal objective of this Statement is to enhance the consistency and comparability of fiduciary activity reporting by state and local governments. This Statement also is intended to improve the usefulness of fiduciary activity information primarily for assessing the accountability of governments in their roles as fiduciaries. This Statement is effective for the Organization for the year ending June 30, 2021.

Note 2 – Summary of Significant Accounting Policies (continued)

In June 2017, the GASB issued Statement No. 87, *Leases*. The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. This Statement requires recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities. This Statement is effective for the Organization for the year ending June 30, 2022.

Note 3 – Cash, Cash Equivalents, and Investments

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

	June 30, 2020	June 30, 2019
Current assets		
Cash and cash equivalents	$ 378,797,374	$ 347,627,785
Investments	724,186,314	573,706,297
Board-designated assets and restricted cash		
Cash and cash equivalents	59,979,769	72,711,832
Investments	582,103,037	547,433,576
Restricted deposit	300,000	300,000
	$ 1,745,366,494	$ 1,541,779,490

Board-designated assets and restricted cash are available for the following purposes:

	June 30, 2020	June 30, 2019
Board-designated assets and restricted cash		
Contingency reserve fund	$ 582,082,806	$ 560,145,408
Homeless Health Initiative fund	60,000,000	60,000,000
Restricted deposit with DMHC	300,000	300,000
	$ 642,382,806	$ 620,445,408

Note 3 – Cash and Investments (continued)

Custodial credit risk deposits – Custodial credit risk is the risk that, in the event of a bank failure, the Organization may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. As of June 30, 2020 and 2019, no deposits were exposed to custodial credit risk, as the Organization has pledged collateral to cover the amounts.

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

Interest rate risk – In accordance with its annual investment policy ("investment policy"), CalOptima manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with CalOptima's expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. CalOptima maintains a low-duration strategy, targeting a portfolio duration of three years or less, with the intent of reducing interest rate risk. Portfolios with low duration are less volatile because they are less sensitive to interest rate changes. As of June 30, 2020 and 2019, CalOptima's investments, including cash equivalents, had the following modified duration:

	June 30, 2020			
		Investment Maturities (in Years)		
Investment Type	Fair Value	Less Than 1	1–5	More Than 5
U.S. Treasury notes	$ 298,007,777	$ 112,195,755	$ 185,812,022	$ -
U.S. Agency notes	231,674,803	173,421,352	58,253,451	-
Corporate bonds	364,552,761	168,166,547	196,386,214	-
Asset-backed securities	111,283,270	8,968,371	102,314,899	-
Mortgage-backed securities	78,468,430	22,578,177	55,890,253	-
Municipal bonds	149,433,887	66,109,199	83,324,688	-
Tax exempt municipal bonds	2,078,441	2,078,441	-	-
Supranational	30,476,401	3,730,227	26,746,174	-
Commercial paper	17,490,611	17,490,611	-	-
Certificates of deposit	18,181,362	18,181,362	-	-
Cash equivalents	311,960,485	311,960,485	-	-
Cash	75,615,576	75,615,576	-	-
	1,689,223,804	$ 980,496,103	$ 708,727,701	$ -
Accrued interest receivable	4,641,608			
	$ 1,693,865,412			

Note 3 – Cash and Investments (continued)

	June 30, 2019			
		Investment Maturities (in Years)		
Investment Type	Fair Value	Less Than 1	1–5	More Than 5
U.S. Treasury notes	$ 352,752,967	$ 177,383,066	$ 175,369,901	$ -
U.S. Agency notes	134,989,426	74,775,657	60,213,769	-
Corporate bonds	314,560,151	104,094,228	210,465,923	-
Asset-backed securities	115,144,277	24,318,946	90,825,331	-
Mortgage-backed securities	50,497,865	8,700,919	41,796,946	-
Municipal bonds	76,245,379	32,692,354	43,553,025	-
Supranational	51,319,797	10,022,104	41,297,693	-
Commercial paper	19,932,870	19,932,870	-	-
Cash equivalents	327,611,350	303,607,437	24,003,913	-
Cash	8,572,533	8,572,533	-	-
	1,451,626,615	$ 764,100,114	$ 687,526,501	$ -
Accrued interest receivable	5,711,366			
	$ 1,457,337,981			

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

	June 30,	
	2020	2019
Asset-backed securities	$ 111,283,270	$ 115,144,277
Mortgage-backed securities	78,468,430	50,497,865
	$ 189,751,700	$ 165,642,142

Note 3 – Cash and Investments (continued)

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

Note 3 – Cash and Investments (continued)

As of June 30, 2020, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 490,315,250	N/A	$ 490,315,250	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	263,976,563	N/A	263,976,563	-	-	-	-	-	-
Corporate bonds	322,967,850	A-	-	1,020,286	24,279,656	32,941,534	70,325,043	135,117,495	59,283,836
Floating-rate note securities	78,472,158	A-	-	45,454,305	3,602,221	4,991,379	10,640,919	12,195,291	1,588,043
Asset-backed securities	93,579,787	AAA	-	92,986,592	593,195	-	-	-	-
Mortgage-backed securities	85,144,612	AAA	-	85,144,612	-	-	-	-	-
Municipal bonds	164,026,121	A	-	23,391,998	81,908,281	38,646,322	12,600,146	5,977,109	1,502,265
Supranational	10,109,748	AAA	-	10,109,748	-	-	-	-	-
Certificates of deposit	29,600,401	A1/P1	-	29,600,401	-	-	-	-	-
Commercial paper	70,079,433	A1/P1	-	70,079,433	-	-	-	-	-
Money market mutual funds	85,593,489	AAA	-	85,593,489	-	-	-	-	-
Total	$ 1,693,865,412		$ 754,291,813	$ 443,380,864	$ 110,383,353	$ 76,579,235	$ 93,566,108	$ 153,289,895	$ 62,374,144

Note 3 – Cash and Investments (continued)

As of June 30, 2019, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 399,269,103	N/A	$ 399,269,103	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	268,824,494	N/A	268,824,494	-	-	-	-	-	-
Corporate bonds	278,900,937	A-	-	507,778	12,097,150	40,140,811	70,968,175	91,142,880	64,044,143
Floating-rate note securities	83,274,478	A-	-	37,475,037	5,000,508	7,686,165	10,402,994	11,561,955	11,147,819
Asset-backed securities	86,471,404	AAA	-	86,014,136	457,268	-	-	-	-
Mortgage-backed securities	79,449,452	AAA	-	79,449,452	-	-	-	-	-
Municipal bonds	82,794,419	A	-	9,954,332	33,041,505	23,666,163	10,161,752	5,244,954	725,713
Supranational	17,332,313	AAA	-	17,332,313	-	-	-	-	-
Certificates of deposit	38,245,312	A1/P1	-	38,245,312	-	-	-	-	-
Commercial paper	78,248,965	A1/P1	-	78,248,965	-	-	-	-	-
Money market mutual funds	44,527,104	AAA	-	44,527,104	-	-	-	-	-
Total	$ 1,457,337,981		$ 668,093,597	$ 391,754,429	$ 50,596,431	$ 71,493,139	$ 91,532,921	$ 107,949,789	$ 75,917,675

Note 3 – Cash and Investments (continued)

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of CalOptima's investment in a single issuer. CalOptima's investment policy limits to no more than 5 percent of the total fair value of investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises, and no more than 10 percent may be invested in one money market mutual fund unless approved by the governing board. The investment policy also places a limit of 35 percent of the amount of investment holdings with any one government-sponsored issuer and 5 percent of all other issuers. As of June 30, 2020 and 2019, all holdings complied with the foregoing limitations. The following holdings exceeded 5 percent of the portfolio as of June 30, 2020 and 2019:

		Percentage of Portfolio June 30,	
Investment Type	Issuer	2020	2019
U.S. Treasury notes	United States Treasury	29.93	29.12
U.S. Agency notes	Federal Home Loan Bank	11.24	14.11

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

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

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

Level 3 – Significant unobservable inputs.

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

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

Note 3 – Cash and Investments (continued)

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

	Investment Assets at Fair Value as of June 30, 2020			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 298,007,777	$ -	$ -	$ 298,007,777
U.S. Agency notes	-	231,674,803	-	231,674,803
Corporate bonds	-	364,552,761	-	364,552,761
Asset-backed securities	-	111,283,270	-	111,283,270
Mortgage-backed securities	-	78,468,430	-	78,468,430
Municipal bonds	-	149,433,887	-	149,433,887
Tax exempt Municipal bonds	-	2,078,441	-	2,078,441
Supranational	-	30,476,401	-	30,476,401
Commercial paper	-	17,490,611	-	17,490,611
Certificates of deposit	-	18,181,362	-	18,181,362
	$ 298,007,777	$ 1,003,639,966	$ -	$ 1,301,647,743

	Investment Assets at Fair Value as of June 30, 2019			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 352,752,967	$ -	$ -	$ 352,752,967
U.S. Agency notes	-	134,989,426	-	134,989,426
Corporate bonds	-	314,560,151	-	314,560,151
Asset-backed securities	-	115,144,277	-	115,144,277
Mortgage-backed securities	-	50,497,865	-	50,497,865
Municipal bonds	-	76,245,379	-	76,245,379
Supranational	-	51,319,797	-	51,319,797
Commercial paper	-	19,932,870	-	19,932,870
	$ 352,752,967	$ 762,689,765	$ -	$ 1,115,442,732

Note 4 – Capital Assets

Capital assets activity during the year ended June 30, 2020, consisted of the following:

	June 30, 2019	Additions	Retirements	Transfers	June 30, 2020
Capital assets not being depreciated					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	499,632	6,838,076	-	(3,959,373)	3,378,335
	6,375,634	6,838,076	-	(3,959,373)	9,254,337
Capital assets being depreciated					
Furniture and equipment	6,601,345	-	-	796,668	7,398,013
Computers and software	30,481,310	-	-	2,007,468	32,488,778
Leasehold improvements	5,063,118	-	-	-	5,063,118
Building	44,588,986	-	-	1,155,237	45,744,223
	86,734,759	-	-	3,959,373	90,694,132
Less: accumulated depreciation for					
Furniture and equipment	5,669,418	485,412	-	-	6,154,830
Computers and software	24,434,229	3,718,911	-	-	28,153,140
Leasehold improvements	3,776,978	586,863	-	-	4,363,841
Building	12,604,876	2,017,206	-	-	14,622,082
	46,485,501	6,808,392	-	-	53,293,893
Total depreciable assets, net	40,249,258	(6,808,392)	-	3,959,373	37,400,239
Capital assets, net	$ 46,624,892	$ 29,684	$ -	$ -	$ 46,654,576

Note 4 – Capital Assets (continued)

Capital asset activity during the year ended June 30, 2019, consisted of the following:

	June 30, 2018	Additions	Retirements	Transfers	June 30, 2019
Capital assets not being depreciated					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	2,382,706	3,692,776	-	(5,575,850)	499,632
	8,258,708	3,692,776	-	(5,575,850)	6,375,634
Capital assets being depreciated					
Furniture and equipment	6,420,961	-	(25,174)	205,558	6,601,345
Computers and software	27,907,888	-	(2,066,669)	4,640,091	30,481,310
Leasehold improvements	5,192,478	-	(138,515)	9,155	5,063,118
Building	43,867,940	-	-	721,046	44,588,986
	83,389,267	-	(2,230,358)	5,575,850	86,734,759
Less accumulated depreciation for					
Furniture and equipment	4,978,434	716,158	(25,174)	-	5,669,418
Computers and software	21,935,365	4,565,533	(2,066,669)	-	24,434,229
Leasehold improvements	3,326,488	589,005	(138,515)	-	3,776,978
Building	10,649,434	1,955,442	-	-	12,604,876
	40,889,721	7,826,138	(2,230,358)	-	46,485,501
Total depreciable assets, net	42,499,546	(7,826,138)	-	5,575,850	40,249,258
Capital assets, net	$ 50,758,254	$ (4,133,362)	$ -	$ -	$ 46,624,892

The Organization recognized depreciation expense of approximately $6,808,000 and $7,826,000 during the years ended June 30, 2020 and 2019, respectively. During the years ended June 30, 2020 and 2019, depreciation expense of approximately $600,000 and $599,000, respectively, was included within PACE medical expenses on the accompanying statements of revenues, expenses, and changes in net position.

Note 5 – Medical Claims Liability

Medical claims liability consisted of the following:

	June 30, 2020	June 30, 2019
Claims payable or pending approval	$ 20,849,394	$ 12,621,260
Provisions for IBNR claims	281,209,114	274,667,344
	$ 302,058,508	$ 287,288,604

Note 5 – Medical Claims Liability (continued)

The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been IBNR. CalOptima estimates accrued claims payable based on historical claims payments and other relevant information. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in medical claims liability. Estimates are continually monitored and analyzed and, as settlements are made or estimates adjusted, differences are reflected in current operations.

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

The following is a reconciliation of the medical claims liability:

	For the Years Ended June 30,	
	2020	2019
Beginning balance	$ 287,288,604	$ 263,057,437
Incurred		
Current	2,172,813,310	1,942,000,378
Prior	(76,706,716)	(6,343,766)
	2,096,106,594	1,935,656,612
Paid		
Current	1,870,754,802	1,669,760,655
Prior	210,581,888	241,664,790
	2,081,336,690	1,911,425,445
Ending balance	$ 302,058,508	$ 287,288,604

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. The results included a decrease of prior year incurred of approximately $76,707,000 and $6,344,000 for the fiscal years ended June 30, 2020 and 2019, respectively. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

Note 5 – Medical Claims Liability (continued)

The amounts accrued in Due to the State of California and CMS represent excess payments from DHCS that are primarily due to capitation payments received that do not reflect the current Medi-Cal rates issued by DHCS. DHCS continues to process the recoupments and the remaining overpayments not yet recouped are included within Due to the State of California and CMS on the statement of net position. During the years ended June 30, 2020 and 2019, DHCS recouped approximately $0 and $152,799,000 related to dates of service of fiscal year 2015 through fiscal year 2019 for the Medi-Cal Expansion population, respectively. This is presented as a reduction of premium revenues in the statements of revenue, expenses, and change in net position. On January 15, 2020, DHCS recouped $10,174,350 relating to the California Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths audit.

Note 6 – Defined Benefit Pension Plan

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

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

Note 6 – Defined Benefit Pension Plan (continued)

The CalPERS Plan's provisions and benefits in effect as of June 30, 2020, are summarized as follows:

Hire date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2% at 60	2% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	monthly for life	monthly for life
Retirement age	50 plus	52 plus
Monthly benefits as a % of eligible compensation	2.0% to 2.7%	1.0% to 2.5%
Required employee contribution rates	7.0%	7.3%
Required employer contribution rates	8.5%	8.5%

The following is a summary of plan participants:

	June 30, 2020	June 30, 2019
Active employees	1,361	1,305
Retirees and beneficiaries		
Receiving benefits	72	72
Deferred retirement benefits		
Terminated employees	202	172
Surviving spouses	3	3
Beneficiaries	3	3

Contributions – Section 20814(c) of the California Public Employees' Retirement Law requires that the employer contribution rates for all public employers are determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. The average active employee contribution rate is 7.75 percent and 7.25 percent of annual pay for the years ended June 30, 2020 and 2019, respectively. The employer's contribution rate is 8.6 percent and 8.5 percent of annual payroll for the years ended June 30, 2020 and 2019, respectively.

Note 6 – Defined Benefit Pension Plan (continued)

CalOptima's net pension liability for the CalPERS Plan is measured as the total pension liability, less the pension plan's fiduciary net position. For the measurement period ended June 30, 2019 (the "measurement date"), the total pension liability was determined by rolling forward the June 30, 2018 total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2019 and June 30, 2018, respectively:

Valuation date	June 30, 2018
Measurement date	June 30, 2019
Actuarial cost method	Entry age normal
Actuarial assumptions	
Discount rate	7.15%
Inflation	2.75%
Salary increases	Varies by entry age and service
Investment rate of return	7.375% net of pension plan investment and administrative expenses; includes inflation
Mortality rate table	Derived using CalPERS' membership data for all funds
Post-retirement benefit increase	Contract COLA up to 2.5% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.50% thereafter

The mortality table used was developed based on CalPERS-specific data. The table includes 15 years of mortality improvements using Society of Actuarials Scale MP 2016. For more details on this table, please refer to the December 2017 experience study report based on CalPERS demographic data from 1997 to 2015 that can be found on the CalPERS website.

Note 6 – Defined Benefit Pension Plan (continued)

Changes in the Net Pension Liability are as follows:

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2019	$ 161,697,511	$ 138,095,447	$ 23,602,064
Changes during the year			
Service cost	14,303,164	-	14,303,164
Interest on the total pension liability	12,107,314	-	12,107,314
Differences between expected and actual experience	1,904,567	-	1,904,567
Contributions from the employer	-	8,661,466	(8,661,466)
Contributions from employees	-	6,853,391	(6,853,391)
Net investment income	-	9,377,613	(9,377,613)
Benefit payments, including refunds of employee contributions	(2,841,212)	(2,841,212)	-
Administrative expenses	-	(98,234)	98,234
Net changes during the year	25,473,833	21,953,024	3,520,809
Balance at June 30, 2020	$ 187,171,344	$ 160,048,471	$ 27,122,873

Note 6 – Defined Benefit Pension Plan (continued)

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2018	$ 142,448,307	$ 117,347,487	$ 25,100,820
Changes during the year			
Service cost	13,491,596	-	13,491,596
Interest on the total pension liability	10,431,464	-	10,431,464
Differences between expected and actual experience	2,812,748	-	2,812,748
Changes of assumptions	(4,737,905)	-	(4,737,905)
Contributions from the employer	-	7,588,200	(7,588,200)
Contributions from employees	-	6,213,420	(6,213,420)
Net investment income	-	10,225,467	(10,225,467)
Benefit payments, including refunds of employee contributions	(2,748,699)	(2,748,699)	-
Administrative expenses	-	(530,428)	530,428
Net changes during the year	19,249,204	20,747,960	(1,498,756)
Balance at June 30, 2019	$ 161,697,511	$ 138,095,447	$ 23,602,064

Discount rate and long term rate of return – The discount rate used to measure the total pension liability for PERF C was 7.15 percent. The projection of cash flows used to determine the discount rate assumed that contributions from plan members will be made at the current member contribution rates and that contributions from employers will be made at statutorily required rates, actuarially determined. Based on those assumptions, the Plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

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

Note 6 – Defined Benefit Pension Plan (continued)

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Using historical returns of all of the funds' asset classes, expected compound (geometric) returns were calculated over the short-term (first 10 years) and the long-term (11+ years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the rounded single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equal to the single equivalent rate calculated above and adjusted to account for assumed administrative expenses.

The table below reflects long-term expected real rate of return by asset class.

New Strategic Asset Class	Real Return Allocation	Real Return Years 1–10 (a)	Years 11+ (b)
Global equity	50.0%	4.80%	5.98%
Global fixed income	28.0%	1.00%	2.62%
Inflation sensitive	0.0%	0.77%	1.81%
Private equity	8.0%	6.30%	7.23%
Real estate	13.0%	3.75%	4.93%
Liquidity	1.0%	0.00%	-0.92%

(a) An expected inflation of 2.00% was used for this period
(b) An expected inflation of 2.92% was used for this period

Note 6 – Defined Benefit Pension Plan (continued)

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

	June 30, 2020		
	Discount Rate -1% 6.15%	Current Discount Rate 7.15%	Discount Rate +1% 8.15%
Net pension liability	$ 58,702,340	$ 27,122,873	$ 1,654,408

	June 30, 2019		
	Discount Rate -1% 6.15%	Current Discount Rate 7.15%	Discount Rate +1% 8.15%
Net pension liability	$ 50,790,772	$ 23,602,064	$ 1,662,185

Note 6 – Defined Benefit Pension Plan (continued)

Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima recognized pension expense of approximately $13,356,000 and $11,422,000, presented within salaries, wages, and employee benefits in the statements of revenue, expenses, and change in net position for the years ended June 30, 2020 and 2019, respectively. As of June 30, 2020 and 2019, CalOptima recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	June 30, 2020	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 1,047,297	$ -
Changes in assumptions	5,060,465	3,728,725
Differences between expected and actual experiences	4,280,308	506,547
	$ 10,388,070	$ 4,235,272

	June 30, 2019	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 686,962	$ -
Net differences between projected and actual earnings on plan investments	-	156,330
Changes in assumptions	6,428,159	4,747,505
Differences between expected and actual experiences	3,419,328	-
	$ 10,534,449	$ 4,903,835

Note 6 – Defined Benefit Pension Plan (continued)

The deferred outflows of resources related to employer contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability during the year ended June 30, 2020. The net differences reported as deferred outflows of resources related to pensions will be recognized as pension expense as follows:

Years Ending June 30,	Deferred Outflows of Resources
2020	$ 1,760,624
2021	493,584
2022	1,361,066
2023	1,208,115
2024	83,129
Thereafter	198,983
	$ 5,105,501

Note 7 – Employee Benefit Plans

Deferred compensation plan – CalOptima sponsors a deferred compensation plan created in accordance with Internal Revenue Code Section 457 (the "457 Plan") under which employees are permitted to defer a portion of their annual salary until future years. CalOptima may make discretionary contributions to the 457 Plan as determined by the Board of Directors. For the years ended June 30, 2020 and 2019, no discretionary employer contributions were made.

Defined contribution plan – Effective January 1, 1999, CalOptima established a supplemental retirement plan for its employees called the CalOptima Public Agency Retirement System Defined Contribution Supplemental Retirement Plan ("PARS Plan"). All regular and limited-term employees are eligible to participate in the PARS Plan. The current PARS Plan design does not require employee contributions. CalOptima makes discretionary employer contributions to the PARS Plan as authorized by the Board of Directors. Vesting occurs over 16 quarters of service. For the years ended June 30, 2020 and 2019, CalOptima contributed approximately $3,533,000 and $3,256,000, respectively.

Note 8 – Postemployment Health Care Plan

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

Note 8 – Postemployment Health Care Plan (continued)

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

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

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

U.S. GAAP requires that the reported results must pertain to liability and asset information within certain defined timeframes. For this report, the following timeframes are used:

Measurement date	June 30, 2019
Measurement period	July 1, 2018 – June 30, 2019
Valuation date	January 1, 2020

Covered employees – The following numbers of participants were covered by the benefit terms:

	June 30, 2020	June 30, 2019
Inactives currently receiving benefits	72	66
Inactives entitled to but not yet receiving benefits	-	-
Active employees	76	83
Total	148	149

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Note 8 – Postemployment Health Care Plan (continued)

Contributions – The contribution requirements of plan members and CalOptima are established and may be amended by the Board of Directors. CalOptima's contribution is based on projected pay-as-you-go financing requirements, with no additional amount to prefund benefits. CalOptima contributed $570,000, including $532,000 in premium payments for retirees and $38,000 for implied subsidies, for the year ended June 30, 2020. CalOptima contributed $556,000, including $523,000 in premium payments for retirees and $33,000 for implied subsidies, for the year ended June 30, 2019. The most recent actuarial report for the postemployment health care plan was June 30, 2019. As of that point, the actuarial accrued liability and unfunded actuarial accrued liability for benefits were approximately $25,824,000.

Actuarial assumptions – CalOptima's total postemployment retirement liability was measured as of June 30, 2018, and the total postemployment retirement liability used to calculate the total postemployment retirement liability was determined by an actuarial valuation dated June 30, 2018, that was rolled forward to determine the June 30, 2019 total postemployment retirement liability, based on the following actuarial methods and assumptions:

Salary increases	3% per annum, in aggregate
Medical trend	Non-Medicare – 7.25% for 2021, decreasing to an ultimate rate of 4.0% in 2076 Medicare – 6.5% for 2021, decreasing to an ultimate rate of 4.0% in 2076
Discount rate	3.50% at June 30 2019, Bond Buyer 20 Index 3.87% at June 30 2018, Bond Buyer 20 Index
Mortality, retirement, disability, termination	CalPERS 1997-2015 Experience Study Post-retirement mortality projection Scale MP-2019
General inflation	2.75% per annum

Discount rate and long-term rate of return – The discount rate used to measure the total OPEB liability was 3.5 percent for June 30, 2019. There were no plan investments; as such, the expected long-term rate of return on investment is not applicable.

Note 8 – Postemployment Health Care Plan (continued)

Changes in the net OPEB liability – Changes in the net OPEB liability were as follows:

Balance at June 30, 2019	$ 24,705,000
Changes for the year	
Service cost	832,000
Interest	977,000
Actual vs. expected experience	(1,072,000)
Assumption changes	938,000
Benefit payments	(556,000)
Net changes	1,119,000
Balance at June 30, 2020	$ 25,824,000
Balance at June 30, 2018	$ 24,565,000
Changes for the year	
Service cost	867,000
Interest	900,000
Assumption changes	(1,067,000)
Benefit payments	(560,000)
Net changes	140,000
Balance at June 30, 2019	$ 24,705,000

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (2.50 percent) or 1 percentage point higher (4.50 percent) than the current discount rate:

	1% Decrease (2.50%)	Current Rate (3.50%)	1% Increase (4.50%)
Total OPEB liability	$ 29,885,000	$ 25,824,000	$ 22,533,000

Note 8 – Postemployment Health Care Plan (continued)

Sensitivity of the net OPEB liability to changes in health care cost trend rates – The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using health care cost trend rates that are 1 percentage point lower or 1 percentage point higher than the current health care cost trend rates:

	1% Decrease	Current Rate	1% Increase
Total OPEB liability	$ 22,056,000	$ 25,824,000	$ 30,564,000

For the years ended June 30, 2020 and 2019, CalOptima recognized OPEB expense of approximately $911,000 and $902,000, respectively. As of June 30, 2020 and 2019, the reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	June 30, 2020	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 804,000
Changes in assumptions	703,000	1,638,000
Employer contributions made subsequent to measurement date	570,000	-
Total	$ 1,273,000	$ 2,442,000

	June 30, 2019	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ -
Changes in assumptions	-	2,503,000
Employer contributions made subsequent to measurement date	556,000	-
Total	$ 556,000	$ 2,503,000

Note 8 – Postemployment Health Care Plan (continued)

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

	Deferred Inflows of Resources
Years Ending June 30,	
2021	$ (898,000)
2022	(711,000)
2023	(130,000)
	$ (1,739,000)

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

Note 9 – Restricted Net Position

On June 28, 2000, CalOptima became a fully licensed health care service plan under the Act, as required by statutes governing the Healthy Families program. Under the Act, CalOptima is required to maintain and meet a minimum level of TNE as of June 30, 2020 and 2019, of $100,573,921 and $84,930,126, respectively. As of June 30, 2020 and 2019, the Organization is in compliance with its TNE requirement.

The Act further required that CalOptima maintain a restricted deposit in the amount of $300,000. CalOptima met this requirement as of June 30, 2020 and 2019.

Note 10 – Lease Commitments

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

	Minimum Lease Payments
Years Ending June 30,	
2021	$ 547,353
2022	277,721
	$ 825,074

Note 10 – Lease Commitments (continued)

Rental expense under operating leases was approximately $471,000 for the years ended June 30, 2020 and 2019.

Note 11 – Contingencies

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

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

Note 12 – Consolidating Information

The consolidating assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position as of June 30, 2019, are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 347,627,785	$ -	$ -	$ 347,627,785
Investments	573,706,297	-	-	573,706,297
Premiums due from the State of California and CMS	302,964,503	-	-	302,964,503
Prepaid expenses and other	54,765,005	-	-	54,765,005
Total current assets	1,279,063,590	-	-	1,279,063,590
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH				
Cash and cash equivalents	72,711,832	-	-	72,711,832
Investments	547,433,576	-	-	547,433,576
Restricted deposit	300,000	-	-	300,000
	620,445,408	-	-	620,445,408
CAPITAL ASSETS, NET	46,624,892	-	-	46,624,892
Total assets	1,946,133,890	-	-	1,946,133,890
DEFERRED OUTFLOWS OF RESOURCES				
Net pension	10,534,449	-	-	10,534,449
Other postemployment benefit	556,000	-	-	556,000
Total deferred outflows of resources	11,090,449	-	-	11,090,449
Total assets and deferred outflows of resources	$ 1,957,224,339	$ -	$ -	$ 1,957,224,339
LIABILITIES AND NET POSITION				
CURRENT LIABILITIES				
Medical claims liability and capitation payable				
Medical claims liability	$ 287,288,604	$ -	$ -	$ 287,288,604
Provider capitation and withholds	108,903,139	-	-	108,903,139
Accrued reinsurance costs to providers	3,209,901	-	-	3,209,901
Due to the State of California and CMS	496,690,411	-	-	496,690,411
Unearned revenue	50,147,341	-	-	50,147,341
	946,239,396	-	-	946,239,396
Accounts payable and other	8,658,894	-	-	8,658,894
Accrued payroll and employee benefits and other	11,069,278	-	-	11,069,278
Total current liabilities	965,967,568	-	-	965,967,568
POSTEMPLOYMENT HEALTH CARE PLAN	24,705,000	-	-	24,705,000
NET PENSION LIABILITY	23,602,064	-	-	23,602,064
Total liabilities	1,014,274,632	-	-	1,014,274,632
DEFERRED INFLOWS OF RESOURCES				
Net pension	4,903,835	-	-	4,903,835
Other postemployment benefit	2,503,000	-	-	2,503,000
Total deferred inflows of resources	7,406,835	-	-	7,406,835
NET POSITION				
Net investment in capital assets	46,580,380	-	-	46,580,380
Restricted by legislative authority	84,930,126	-	-	84,930,126
Unrestricted	804,032,366	-	-	804,032,366
Total net position	935,542,872	-	-	935,542,872
Total liabilities, deferred inflows of resources, and net position	$ 1,957,224,339	$ -	$ -	$ 1,957,224,339

Note 12 – Consolidating Information (continued)

The consolidating statements of revenues, expenses, and changes in net position for the year ended June 30, 2019, are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
REVENUES				
Premium revenues	$ 3,474,634,375	$ -	$ -	$ 3,474,634,375
Total operating revenues	3,474,634,375	-	-	3,474,634,375
OPERATING EXPENSES				
Medical expenses				
Claims expense to providers and facilities	1,287,230,443	-	-	1,287,230,443
Provider capitation	1,094,332,595	-	-	1,094,332,595
Prescription drugs	445,721,355	-	-	445,721,355
OneCare Connect	293,947,460	-	-	293,947,460
Other medical	53,871,235	-	-	53,871,235
Pace	23,297,732	-	-	23,297,732
OneCare	18,272,703	-	-	18,272,703
Total medical expenses	3,216,673,523	-	-	3,216,673,523
Administrative expenses				
Salaries, wages, and employee benefits	84,618,793	-	-	84,618,793
Supplies, occupancy, insurance, and other	22,963,749	12,000	-	22,975,749
Purchased services	12,584,719	-	-	12,584,719
Depreciation	7,226,723	-	-	7,226,723
Professional fees	3,167,619	-	-	3,167,619
Total administrative expenses	130,561,603	12,000	-	130,573,603
Total operating expenses	3,347,235,126	12,000	-	3,347,247,126
OPERATING INCOME (LOSS)	127,399,249	(12,000)	-	127,387,249
NON-OPERATING REVENUES				
Net investment income and other	43,640,102	35,771	-	43,675,873
Total non-operating revenues	43,640,102	35,771	-	43,675,873
Increase in net position	171,039,351	23,771	-	171,063,122
NET POSITION, beginning of year	761,636,611	2,843,139	-	764,479,750
Transfer of Foundation assets to CalOptima	2,866,910	(2,866,910)	-	-
NET POSITION, end of year	$ 935,542,872	$ -	$ -	$ 935,542,872

Note 12 – Consolidating Information (continued)

The consolidating statement of cash flows for the year ended June 30, 2019, is as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERATING ACTIVITIES				
Capitation payments received and other	$ 3,335,206,230	$ -	$ -	$ 3,335,206,230
Payments to providers and facilities	(3,180,342,695)	-	-	(3,180,342,695)
Payments to vendors	(61,176,697)	(12,000)	-	(61,188,697)
Payments to employees	(81,658,054)	-	-	(81,658,054)
Net cash provided by (used in) operating activities	12,028,784	(12,000)	-	12,016,784
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES				
Purchases of capital assets	(3,692,776)	-	-	(3,692,776)
Net cash used in capital and related financing activities	(3,692,776)	-	-	(3,692,776)
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment income received	49,351,468	35,771	-	49,387,239
Purchases of securities	(13,023,305,579)	-	-	(13,023,305,579)
Sales of securities	12,942,289,130	-	-	12,942,289,130
Net cash (used in) provided by investing activities	(31,664,981)	35,771	-	(31,629,210)
Net (decrease) increase in cash and cash equivalents	(23,328,973)	23,771	-	(23,305,202)
CASH AND CASH EQUIVALENTS, beginning of year	368,089,848	2,843,139	-	370,932,987
Transfer of Foundation assets to CalOptima	2,866,910	(2,866,910)	-	-
CASH AND CASH EQUIVALENTS, end of year	$ 347,627,785	$ -	$ -	$ 347,627,785

Supplementary Information

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

Schedule of Changes in Net Pension Liability and Related Ratios

	June 30,					
	2020	2019	2018	2017	2016	2015
Total pension liability						
Service cost	$ 14,303,164	$ 13,491,596	$ 13,118,795	$ 10,272,406	$ 8,363,183	$ 6,464,105
Interest	12,107,314	10,431,464	9,136,725	7,702,198	6,620,025	5,661,111
Differences between expected and actual experience	1,904,567	2,812,748	632,642	102,384	1,444,808	-
Changes in assumptions	-	(4,737,905)	9,163,547	-	(1,963,270)	-
Benefit payments, including refunds of employee contributions	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Net change in total pension liability	25,473,833	19,249,204	29,983,353	15,965,410	12,788,080	10,798,852
Total pension liability – beginning	161,697,511	142,448,307	112,464,954	96,499,544	83,711,464	72,912,613
Total pension liability – ending	187,171,344	161,697,511	142,448,307	112,464,954	96,499,544	83,711,465
Plan fiduciary net position						
Contributions – employer	8,661,466	7,588,200	5,234,580	3,787,544	3,033,171	3,119,804
Contributions – employee	6,853,391	6,213,420	5,793,911	4,951,820	4,142,126	3,385,296
Net investment income	9,377,613	10,225,467	11,496,425	498,498	1,913,380	12,062,654
Benefit payments, including refunds of employee contrbutions	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Other changes in fiduciary net position	(98,234)	(530,428)	(143,264)	(54,828)	(101,246)	-
Net change in fiduciary net position	21,953,024	20,747,960	20,313,296	7,071,456	7,310,765	17,241,390
Plan fiduciary net position – beginning	138,095,447	117,347,487	97,034,191	89,962,735	82,651,970	65,410,580
Plan fiduciary net position – ending	160,048,471	138,095,447	117,347,487	97,034,191	89,962,735	82,651,970
Plan net pension liability – ending	$ 27,122,873	$ 23,602,064	$ 25,100,820	$ 15,430,763	$ 6,536,809	$ 1,059,495
Plan fiduciary net position as percentage of the total liability	85.51%	85.40%	82.38%	86.28%	93.23%	98.73%
Covered-employee payroll	$ 91,587,145	$ 85,764,390	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Plan net pension liability as a percentage of covered employee payroll	29.61%	27.52%	31.29%	22.50%	11.74%	2.59%

See accompanying report of independent auditors.

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

	Years Ended June 30,					
	2020	2019	2018	2017	2016	2015
Actuarially determined contributions	$ 8,661,466	$ 7,588,200	$ 5,234,580	$ 3,787,544	$ 3,033,171	$ 3,119,804
Contributions in relation to the actuarially determined contribution	(8,661,466)	(7,588,200)	(5,234,580)	(3,787,544)	(3,033,171)	(3,119,804)
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -
Covered-employee payroll	$ 91,587,145	$ 85,764,390	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Contributions as a percentage of covered-employee payroll	9.46%	8.85%	6.53%	5.52%	5.45%	7.62%

See accompanying report of independent auditors.

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

Schedule of Changes in Total OPEB Liability and Related Ratios

	2019–2020 (Measurement Period 2018–2019)	2018–2019 (Measurement Period 2017–2018)
Changes in total OPEB liability		
Service cost	$ 832,000	$ 867,000
Interest	977,000	900,000
Actual vs. expected experience	(1,072,000)	-
Assumption changes	938,000	(1,067,000)
Benefit payments	(556,000)	(560,000)
Net changes	1,119,000	140,000
Total OPEB liability (beginning of year)	24,705,000	24,565,000
Total OPEB liability (end of year)	$ 25,824,000	$ 24,705,000
Total OPEB liability	$ 25,824,000	$ 24,705,000
Covered employee payroll	8,353,000	8,150,000
Total OPEB liability as a percentage of covered employee payroll	309.2%	303.1%

See accompanying report of independent auditors.

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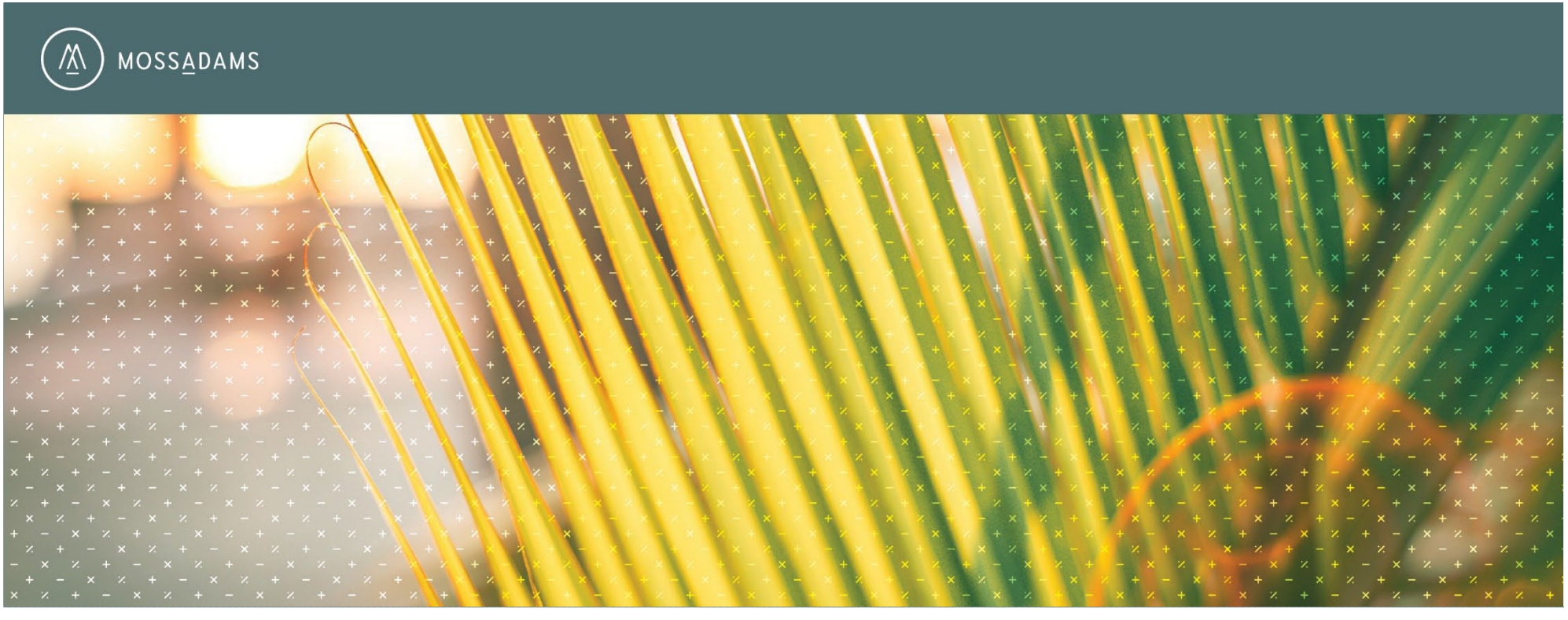

Audit Results – CalOptima

Prepared by the Moss Adams Health Care Group

September 17, 2020

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Finance and Audit Committee

CalOptima

Dear Finance and Audit Committee (FAC) Members:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the financial statements of CalOptima (the “Organization”) for the year ended June 30, 2020.

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

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

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

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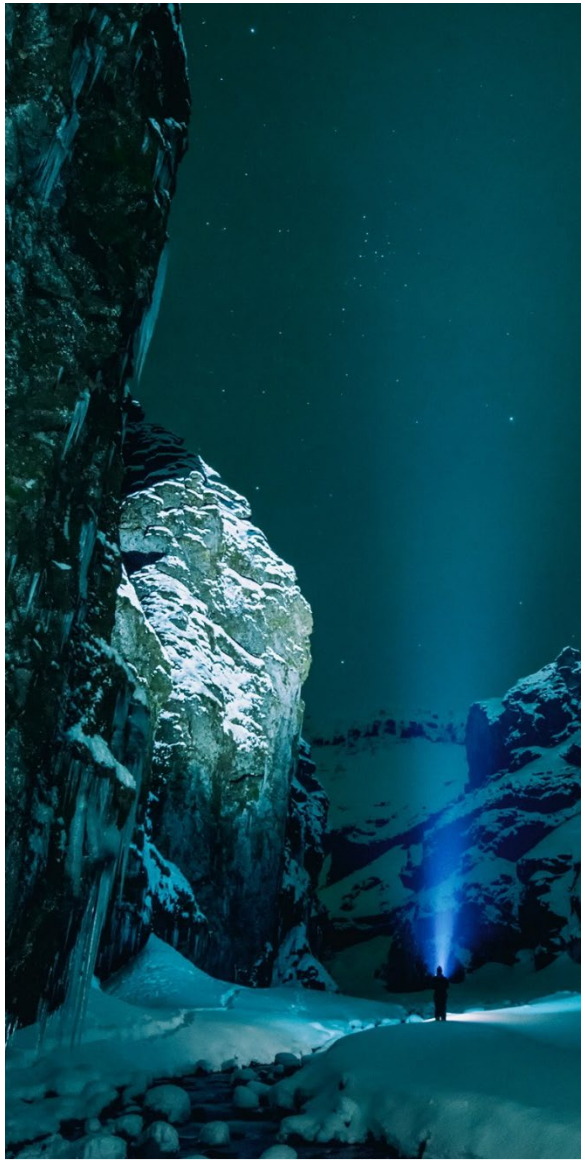

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1. Auditor Opinions and Reports
2. Communications with the Finance and Audit Committee
3. Other Information

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Auditor Opinions & Reports



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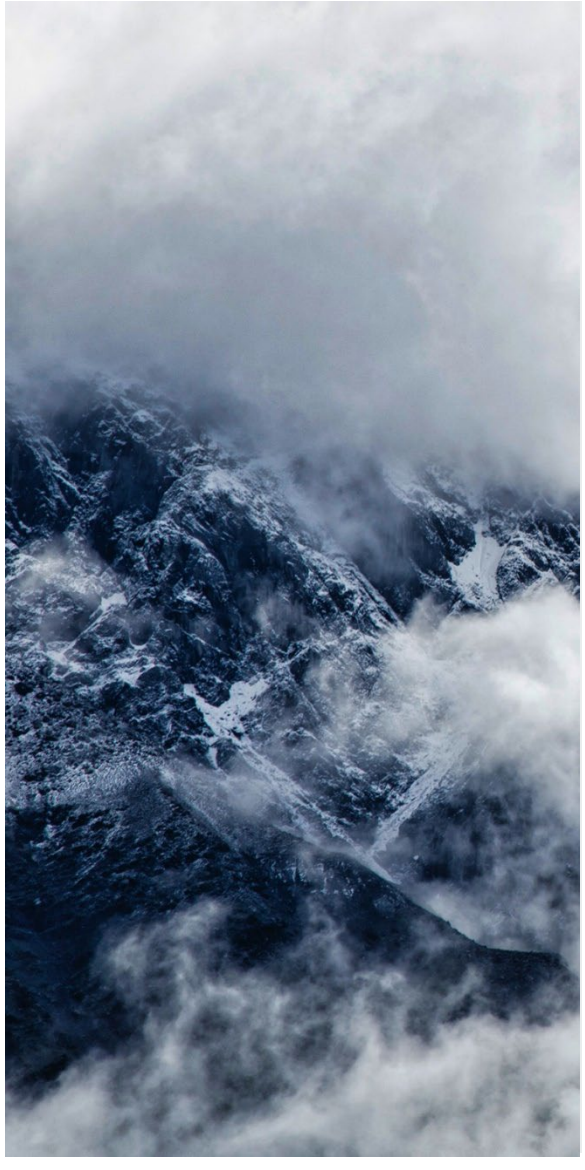
Scope of Services

We have performed the following services for CalOptima:

- Annual financial statement audit as of and for the year ended June 30, 2020

We have also performed the following nonattest services:

- Assisted in the drafting the financial statements of CalOptima, excluding Management's Discussion and Analysis
- Assisted in the completion of the Auditee portion of the Data Collection Form



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Auditor Report on the Financial Statements

Unmodified Opinion

- Financial statements are presented fairly and in accordance with U.S. Generally Accepted Accounting Principles (GAAP)



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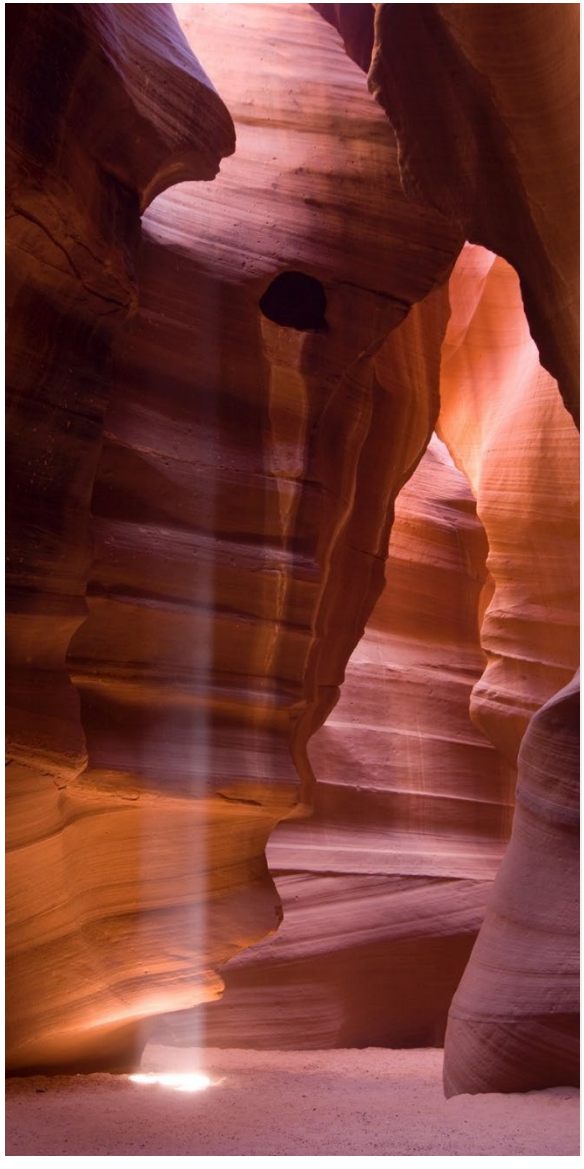
Communications with the Finance and Audit Committee (FAC)



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Our Responsibility

			
To express our opinion on whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.	To perform an audit in accordance with generally accepted auditing standards issued by the AICPA, Government Auditing Standards issued by the Comptroller General of the United States, and design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement.	To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.	To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

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Planned Scope & Timing of the Audit

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

Our Comments

The planned scope and timing of the audit was communicated to the FAC at the audit entrance meeting on May 21, 2020.

Significant Accounting Policies & Unusual Transactions

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

Our Comments

Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the Organization are described in the footnotes to the financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2020.

We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Management Judgements & Accounting Estimates

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

Our Comments

Management's judgements and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the financial statements.

Significant management estimates impacted the financial statements including the following: **fair value of investments; fixed asset lives; actuarially determined accruals for incurred but not reported (IBNR), medical claims liabilities, other non-IBNR medical liabilities, pension, and other postemployment liabilities.**

We deem them to be reasonable.

Areas of Audit Emphasis

	Medical Claims Liability and Claims Expense
	Capitation Revenue and Receivables
	Amounts due to the State of California or DHCS
	Pension Liability
	Other Postemployment Benefits (OPEB) Liability

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Management Judgments & Accounting Estimates

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

Our Comments

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

- Note 2 – Summary of Significant Accounting Policies
- Note 3 – Cash and Investments
- Note 5 – Medical Claims Liability
- Note 6 – Defined Benefit Pension Plan
- Note 8 – Postemployment Health Care Plan

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

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

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

Our Comments

CORRECTED ADJUSTMENTS:

- We proposed, and the Organization recorded, a reclassifying entry of approximately $92 million to properly reflect cash and cash equivalents and investments.

UNCORRECTED ADJUSTMENTS:

- There were no uncorrected audit adjustments.

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Deficiencies in Internal Control and in Internal Control over Compliance

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

Our Comments

MATERIAL WEAKNESS:

- None noted

SIGNIFICANT DEFICIENCIES:

- Nothing to communicate

NONCOMPLIANCE:

- Nothing to communicate

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

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

Our Comments

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

Difficulties Encountered in Performing the Audit

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

Our Comments

No significant difficulties were encountered during the audit.

We are pleased to report that there were no disagreements with management.

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

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

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

Our Comments

No such matters came to our attention.

We have not become aware of any instances of fraud or noncompliance with laws and regulations.

Other Material Written Communications

Report to the FAC significant written communications between the auditor and management.

Our Comments

We have requested certain representations from management that will be included in the representation letter, which we will receive prior to issuance.

Other than the engagement letter, management representation letter, and communication to the FAC, there have been no other significant communications.

Management's Consultation with Other Accountants

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

Our Comments

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

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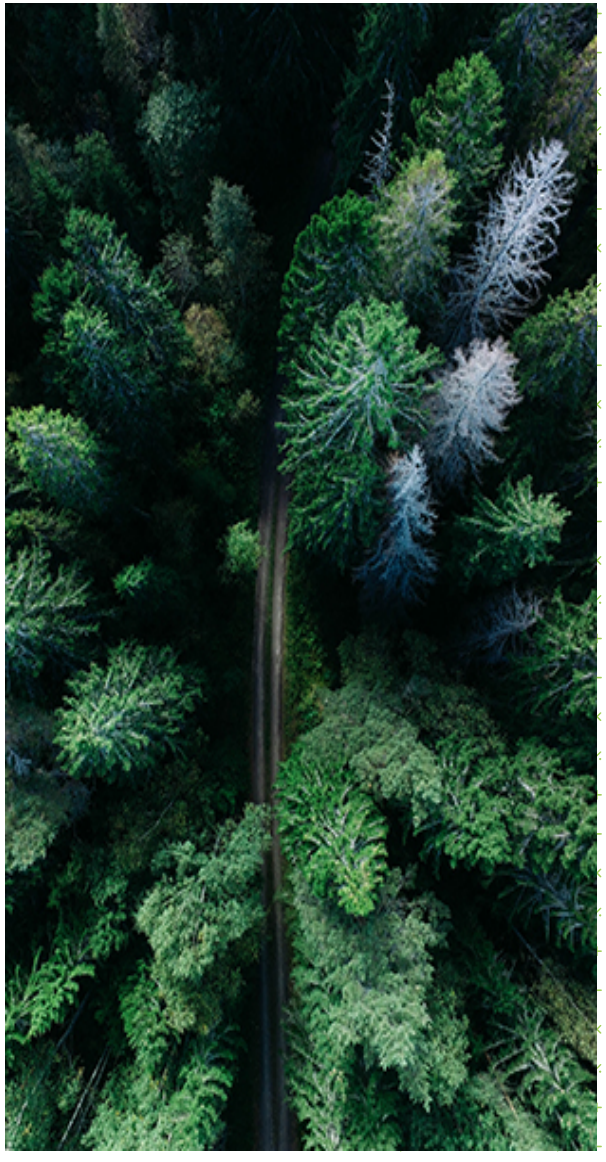
About Moss Adams



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Our Response to COVID-19

The COVID-19 pandemic has touched all aspects of our lives. We're here to guide you to the information and resources you need now and provide strategies for the changes to come. We'll support you as you rebuild and help you take advantage of rising opportunities.

NAVIGATE

- Stay up-to-date with guidance and support to help combat uncertainty
- Reach out to your Moss Adams professional with any questions on the most current updates and advisements

ARTICLE

- Weather COVID-19 Market Volatility: Investments, Finances, and Tax Planning

REBUILD

- Strategize needs and be aware of what's to come
  - We'll connect you with the right resource, either within the greater Moss Adams team or through our various industry contacts
- Review Moss Adams announcements that provide tax and regulatory relief

ALERTS

- CARES Act Overview: Implications for Business Taxpayers
- CARES Act: Implications for Individual Taxpayers

THRIVE

- Take steps to bolster your workforce and organization
- Evaluate additional service needs, such as the following:
  - Capital sourcing
  - Cloud tools
  - Cost segregation
  - Enterprise resource planning
  - Estate and succession planning
  - Financial planning
  - Forecasting
  - IT security and cybersecurity
  - Process improvement
  - Outsourced finance accounting
  - R&D tax credits
  - Risk assessment
  - State and local tax
  - Transactions services

HELPING YOU ADAPT TO UNCERTAIN TIMES

Find more information and resources here: https://mossadams.com/covid-19-implications

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THANK YOU

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Actions
Recommend ratification and authorization of unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $137,802.

Background
On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with other federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

At its April 2, 2020, meeting, the CalOptima Board of Directors ratified and authorized unbudgeted expenditures for emergency purchases to support coronavirus mitigation strategies, including CalOptima's Temporary Telework process, in an amount not to exceed $915,000.

At its April 16, 2020, meeting, the Board ratified and authorized additional unbudgeted expenditures for emergency purchases related to the coronavirus pandemic not to exceed $80,327.

Discussion
To protect employees during the pandemic, CalOptima has implemented various infection control measures consistent with the guidelines provided by the CDC and other regulatory agencies. Additional expenditures are necessary as part of CalOptima's continued efforts to provide health and safety measures to protect employees who are working in the CalOptima facilities. Staff recommends the Board ratify and authorize unbudgeted expenditures for the following emergency purchases related to the coronavirus pandemic:

Department	Description	Amount
PACE	Staff personal protective equipment	$21,300
Facilities	Staff personal protective equipment	$8,780
	Gloves, disinfectant products	$11,653
	Thermometers	$2,069
	Estimated expenses for disinfectant products ($1,000/month) and other COVID-related supplies from July 1, 2020, through December 31, 2020	$19,000

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Department	Description	Amount
Facilities and Payroll	2 temporary staff in Facilities to perform remote workplace evaluation. 1 temporary staff in Payroll to: • Improve timekeeping management process during Temporary Telework deployment; and • Assist with handling and processing of paperwork, and other support during the pandemic.	$75,000
	Total	**$137,802**

CalOptima contracted with the existing vendors to ensure timely and efficient service and delivery of the required equipment and products for the protection and security of CalOptima's employees and members. Emergency purchases with contracted vendors were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Fiscal Impact
The recommended action to ratify and authorize unbudgeted expenditures for emergency purchases to support CalOptima's continued response to the public health emergency related to the coronavirus pandemic is unbudgeted. An allocation of up to $137,802 from existing reserves will fund these actions.

Rationale for Recommendation
Ratification and authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members during the coronavirus pandemic.

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

Attachments
1. Board Action dated April 2, 2020, Consider Ratification of Actions Taken in Response to the Public Health Emergency Arising from the Coronavirus (COVID-19) Pandemic
2. Board Action dated April 16, 2020, Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic

/s/ Richard Sanchez — *09/23/2020*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Ratification of Actions Taken in Response to the Public Health Emergency Arising from the Coronavirus (COVID-19) Pandemic

Contact

Candice Gomez, Executive Director Program Implementation, (714) 246-8400
Brigette Gibb, Executive Director Human Resources, (714) 246-8400

Recommended Actions

1. Ratify the implementation of mitigation strategies to slow the transmission of COVID-19 through temporary telework for CalOptima employees; and
2. Ratify unbudgeted expenditures from existing reserves for emergency purchases to support these mitigation strategies, including CalOptima's Temporary Telework process in the amount not to exceed $915,000

Background

On January 31, 2020, the Secretary of U.S. Department of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On February 27, 2020, Orange County declared a local health emergency. The Governor of California declared a State of Emergency on March 4, 2020. On March 11, 2020, the World Health Organization declared the coronavirus a pandemic. On March 13, 2020, the President declared a national emergency based on the spread of the coronavirus.

On March 11, 2020, the Orange County Health Care Agency provided recommendations for COVID-19 community mitigation strategies. While social distancing has been encouraged to limit the spread of COVID-19, beginning on March 17, 2020, state and local agencies began implementing stay-at-home orders to prohibit professional, social, and community gatherings outside of a list of "essential activities."

Discussion

Along with federal, state, and local agencies, CalOptima management has been actively engaged in efforts to evaluate business needs and protect the health and safety of CalOptima employees, members, providers, and our community, and mitigate the spread and limit exposure to the disease. CalOptima management has been closely monitoring this public health emergency and taking preventive actions based on information and guidelines provided by federal, state, and local agencies including, but not limited to, the Centers for Disease Control and Prevention (CDC), the California Department of Public Health, and the Orange County Health Care Agency.
The health and safety of CalOptima employees is critical to ensuring business continuity and access to health care services for CalOptima members. CalOptima has considered the following objectives in evaluating the organization's response to the pandemic as the current situation constantly evolves:

- Maintaining continuity of essential services and business functions while maintaining a safe work environment for CalOptima employees;

- Maximizing social distancing and limiting group meetings and interactions that might spread COVID-19;
- Developing flexible work arrangements for employees as appropriate;
- Maintaining a unified response consistent with actions taken by state and local government; and
- Ensuring that CalOptima is transparent in its processes and communications to its employees, providers and members.

CalOptima's operations are considered part of the critical infrastructure in both the healthcare/public health sector as well as the government sector. As an essential business, CalOptima's operations must continue to be fully functioning and effective. As part of business continuity and emergency planning, CalOptima management has evaluated job functions, and categorized CalOptima staff according to the following five categories:

1. Job duties cannot be performed remotely;
2. Job duties can be performed remotely;
3. Job duties support essential functions in the 505 City Parkway West building:
    - Facility support
    - Building security
    - Building management
    - Information Services 3rd Shift
    - Information Services Help Desk
    - Mail room
    - Member enrollment and reconciliation
    - Finance accounts payable;
4. Job duties support essential functions in the PACE Center, 13300 Garden Grove Blvd:
    - PACE clinic, transportation, and reception staff
    - PACE records management; and
5. Job duties can be performed remotely, but employee's home environment is not conducive to working remotely.

To protect employees during the pandemic, CalOptima management has been implementing infection control and social distancing measures as these are released by the CDC or other regulatory agencies. Based on the guidelines provided by regulatory agencies, on March 13, 2020, CalOptima management has moved forward with its business continuity and emergency plan, and initiated temporary telework for CalOptima staff whose job duties can be performed remotely. In order to institute an orderly process for temporary telework, CalOptima management implemented phases for deployment. This process was made voluntary to employees and only applied to those with job duties that meet the requirements for temporary telework.

> Phase 1: Employees identified in the high risk categories (as defined by CDC guidelines as of March 13, 2020), including those eligible for leave under the Family Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA), or those requiring a reasonable accommodation under the Americans with Disabilities Act (ADA).

Phase 2: Employees who had already been issued the necessary equipment to work remotely.

Phase 3: Employees who had not previously been issued the necessary equipment to work remotely have been and will continue to be deployed when fully equipped and according to job function with the following priority:

a. Employees with direct member interaction (e.g., talk to Members);
b. Employees whose job duties result in an organizational decisions or determinations (e.g., approval, denial, or appeal of medical service authorization requests);
c. All other staff as equipment needs are met.

The temporary telework process was not contemplated as part of CalOptima Policy GA. 8044: Telework Program, and the number of employees on temporary telework exceeds the Board-authorized number of teleworkers (1/3 of CalOptima staff). Currently, approximately 82% of CalOptima employees are working remotely, and management anticipates that this number may increase to as many as 85-90%. Management is seeking Board ratification of the actions taken to respond to the COVID-19 pandemic and implement mitigation strategies by placing employees on temporary telework, which:

(1) Reduces the number of employees present in the administration building and facilitates social distancing measures to mitigate the spread of COVID-19;
(2) Ensures business continuity while employees are working remotely;
(3) Protects the health and safety of CalOptima employees; and
(4) Ensures that CalOptima is continuing to carry out its essential operations by meeting the needs of members and being responsive to providers.

To support temporary telework, CalOptima staff also recommends ratification of unbudgeted expenditures in the amount of $915,000 for equipment and mobile ready software to allow CalOptima employees to work remotely. Expenditures also include replenishment of back-up laptop inventory plus additional laptops for urgent and unforeseeable needs due to COVID-19. The recommended amount of unbudgeted expenditures is based on estimated costs and approximately 10% contingency for unanticipated costs. Estimated itemized costs are as follows:

Item	**Amount**
RSA Tokens to allow connectivity outside of building	$43,911
VPN Licenses to allow connectivity to the CalOptima network	$76,600
IP Softphone Licenses to allow connectivity to the phone system	$259,893
Power Cords	$4,505
Headsets and Headset Adapters	$42,185
Surge Protectors	$10,532
Cables and Soundbars for Computer Monitors	$28,458

ACD License to support phone system	$38,510
Bluecoat Web Security Service (WSS)	$21,970
Computer Monitors	$184,145
Cat6 Patch Cables for Computer Parts	$759
Back-up Laptops	$121,879
Contingency	$81,653
Estimated Costs	$915,000

For employees remaining in the two CalOptima buildings, additional space planning efforts have been implemented to promote social distancing practices. Additional planning is also being evaluated should it be necessary through local, state, or federal action that employees remain locked-down at home and all essential work functions must be performed remotely. CalOptima staff will return to the CalOptima Board of Directors for consideration of future actions as appropriate.

Fiscal Impact

The recommended action to ratify unbudgeted expenditures for emergency purchases to support CalOptima's response to the public health emergency and implementation of temporary telework is unbudgeted. An allocation of up to $915,000 from existing reserves will fund this action.

Rationale for Recommendation

Implementing temporary telework ensures that CalOptima takes appropriate action to not only protect the health and safety of our employees and community during the COVID-19 pandemic, but also ensure that CalOptima members and providers are able to access covered, medically necessary health care services during this pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Temporary Telework Agreement
2. CalOptima Policy GG.8044 Telework Program

/s/ Michael Schrader — *03/26/2020*
Authorized Signature — **Date**

CalOptima Temporary Telework Agreement

Name:	
Title:	
Department:	
Supervisor/Manager:	
Reason for Request:	☐ **Health conditions resulting in a higher risk** ☐ **Direct exposure to individual with COVID-19** ☐ **Suspected exposure to individual with COVID-19** ☐ **Caring for family member with COVID-19** ☐ **Quarantine order by government entity** ☐ **Minor illness or influence/cold-like illness** ☐ **Childcare as a result of school closure** ☐**Specify school district:** _____ ☐**School closure dates:** _____ ☐ **Travel to/from particular locations with known outbreaks** ☐ **Other: Please specify** _____
Temporary Telework Start Date:	
Anticipated Return Date:	

CalOptima recognizes the unique circumstances surrounding the current COVID-19 pandemic and would like to support alternative work arrangements, where feasible, to help protect CalOptima employees and prevent the further spread of the virus. A voluntary temporary telework arrangement is being made available as an alternative method of meeting the work needs of the organization through a flexible work structure for positions where the essential functions of the job can be performed off-site. This temporary telework agreement will commence once approved by the Human Resources Department, and the termination date will be evaluated weekly based on the conditions and circumstances surrounding COVID-19. You may need to take PTO or unpaid leave if you cannot come to the Office, but are either not yet approved for temporary telework or do not yet have the necessary equipment to perform the essential functions of your job position. Please maintain regular contact with your management regarding your attendance, and HR regarding protected leave and/or reasonable accommodations.

I _____, ("Employee") and CalOptima, mutually agree that the
Print Name

Employee is eligible to work at a Remote Work Location, on a temporary basis, commencing on the date approved by HR below pursuant to this Temporary Telework.
Work Agreement (the "Agreement"). This is not considered or counted as a permanent telework position and will only be granted for the amount of time necessary. This privilege is voluntary, temporary and may be terminated at any time by CalOptima, the employee or manager.

Participation:

CalOptima plays a vital role in the community as a resource for care, information, and support. Our focus is to enable our employees to manage the community response and to serve the needs of CalOptima members, while also taking care of our own employees. Employee recognizes that the temporary telework option is voluntary and at the Employee's discretion. This work arrangement may be reassessed, modified and/or terminated by either the employee or CalOptima, with or without notice or cause.

Other than those duties and obligations expressly imposed on the employee under this Agreement, the duties obligations, responsibilities and conditions of Employee's employment with CalOptima remain unchanged. The employee's salary and benefits shall remain unchanged.

Approval of the temporary telework arrangement will be made based on an evaluation of the appropriateness of your position to work from home, the resources available to enable you to work, business priorities, and staffing concerns. Business continuity for critical areas is our utmost priority to ensure CalOptima is providing excellent services to our members and responding in a timely manner to all inquiries and regulatory requirements.

Application of CalOptima Policies, Procedures and Rules:

a. Employee agrees to abide by the terms and requirements of CalOptima Policy GA. 8044: Telework Program and all other applicable CalOptima policies, including, but not limited to, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI-security of CalOptima assets, dependent care, etc.
b. Employee understands and agrees that the temporary telework arrangement is not intended to supersede or override CalOptima's policies, procedures, rules or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules and standards of conduct.

Technological Capabilities: When using CalOptima devices, the Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

Safety and Security: Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure Remote Work Location when working off-site, with particular sensitivity to any protected health information in written or oral form. In the event employee is not working from a Home Office location, any alternative Remote Work Location must be pre-approved by Employee's supervisor.

Confirmation of Agreement:

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that any violation of CalOptima's policies and procedures or any violations of state or federal law while working off-site may result in disciplinary action, up to and including termination, and/or civil or criminal prosecution.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this Agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for temporary telework as set forth by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

CalOptima may terminate this agreement at any time, with or without notice.

Employee:

Print Name	Signature	Date

Immediate Supervisor:

Print Name	Signature	Date

APPROVED BY HUMAN RESOURCES:

Print Name	Signature	Date

Policy #:	GA.8044
Title:	**Telework Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader MS

Effective Date:	03/01/12
Last Review Date:	02/01/18
Last Revised Date:	02/01/18

Board Approved Policy

I. PURPOSE

This policy describes guidelines for a work structure that: 1) permits an employee to perform their work from a Remote Work Location, unless business needs require otherwise; 2) increases quality of life for employees; 3) reduces operation and overhead costs; 4) supports recruitment and retention of skilled employees; and 5) promotes a culture of managing by results.

II. POLICY

A. Telework is a workplace arrangement in which an eligible employee works his or her entire work schedule away from the Central Worksite at a Remote Work Location, unless business needs require otherwise.

1. A partial teleworking arrangement is not allowed. A Teleworker may not elect to routinely work a portion of his or her scheduled days at the Central Worksite and the remainder from the Remote Work Location.

B. Telework is not a universal employee benefit or entitlement, but rather, an alternative method of meeting the work needs of the organization through a flexible work structure. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the telework program based on business needs.

C. Telework is voluntary unless specifically stated as a condition of employment and may be terminated at any time by either the Teleworker or CalOptima, with or without cause.

D. The total number of employees in telework positions at any point in time may equal but not exceed the maximum number telework positions as directed by the CalOptima Board of Directors.

E. Telework positions may be identified as follows:

1. Human Resources (HR) may designate a position as a telework position if it is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework.

2. HR may reserve a number of telework positions for use in granting reasonable work accommodations, for employees transitioning back to work after a qualifying leave of absence, or for other exigencies, which would require the approval of the Executive Director of HR.

3. A department leader may designate one (1) or more positions as suitable for teleworking if the duties and responsibilities of the position can be performed remotely at the same or higher level of productivity and quality compared to working at the Central Worksite.

F. Remote Work exception to the Telework policy: When special circumstances require it, an employee's manager has the discretion to allow an employee, to work from a Remote Work Location on an occasional basis.

1. Occasional is defined as rare, infrequent and not regularly scheduled for brief periods (usually a day or part of a day); with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a telework position.

2. All employees who occasionally work from a Remote Work Location must abide by the same requirements as employees who telework, including, but not limited to, the applicable conditions set forth in this policy concerning terms of employment, work schedule and accessibility, dependent care, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI, establishing a Remote Work Location, security of CalOptima assets, inspection, etc.

3. Furthermore, for departments which permit employees to work from a Remote Work Location, to be eligible to work occasionally from a Remote Work Location, the employee must execute the CalOptima Occasional Off-site Work Agreement and submit the signed document to the Human Resources Department prior to being permitted to work from a Remote Work Location.

G. Terms of Employment

1. The conditions of employment, such as employee salary, benefits and employer-sponsored insurance coverage, will remain the same for an employee designated as a Teleworker as for non-telework employee.

2. CalOptima's policies, rules and practices are applicable to a Teleworker's Remote Work Location, including, but not limited to, confidentiality, internal communications, communications with the public, public records requests, employee rights and responsibilities, facilities and equipment management, financial management, information resource management, purchasing of property and services, unlawful harassment, drug and alcohol, and safety.

3. Telework will be voluntary unless specifically stated as a condition of employment.

4. Other than those additional duties and obligations expressly imposed on a Teleworker under this policy, the duties, obligations, responsibilities and conditions of a Teleworker's employment with CalOptima shall remain unchanged.

H. Teleworker Selection

1. The employee's department manager, with final review and evaluation by HR, shall consider and ensure that the selected employee and their work responsibilities meet the following conditions:

a. The nature of the work and job responsibilities can be performed effectively away from the Central Worksite.

b. The nature of resources and tools necessary for an employee's work assignments and job responsibilities can be accessed from the employee's Home Office location while ensuring confidentiality where necessary and compliance with all applicable laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) regulations.

c. The nature of the work and the employee's job responsibilities do not require daily face-to-face contact with other employees or supervisors, and/or the employee and/or the employee's work does not require supervision that can only be accomplished at the Central Worksite.

d. The nature of the work is not dependent on accessing equipment, materials, files, etc., that are only available in the Central Worksite.

2. To be eligible for telework, the following considerations will be evaluated:

a. Employee must be in good standing, with no prior disciplinary action in the last year or on a Performance Improvement Plan, and may be scheduled for full-time or part-time and/or may be exempt or non-exempt (hourly).

b. Based on business considerations and management discretion, supervisors and managers may be approved for telework only if their entire team teleworks.

c. If supervisors and managers have staff that does not telework and/or are not eligible for telework, they must be present in the office to supervise their non-telework staff.

d. Telework is not available for senior manager level positions and above, unless the position is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework as determined by the Executive Director of Human Resources, with the approval of the Chief Operating Officer.

3. To participate in the telework program, an employee must meet additional eligibility and selection criteria established by CalOptima, including the suitability of performing the requirements of the job from a Remote Work Location and the ability of the employee to meet performance expectations in a work environment away from the Central Worksite.

4. To be eligible to work from a Remote Work Location the employee must obtain approval from the employee's supervisor/manager and director prior to submitting the request to HR. Employees are required to sign and submit the CalOptima Telework Agreement, along with all other required documentation, to the HR Department prior to being deployed.

I. Termination of Telework Arrangement

1. A Teleworker may elect at any time to move from working at a Remote Work Location to working at the Central Worksite, contingent on space availability.

a. The Teleworker must notify and discuss the change with his or her manager and receive approval.

b. The Teleworker's manager will notify HR of the request to terminate the telework arrangement.

2. A Teleworker's manager may change or end the teleworking arrangement at any time based on business needs, performance or productivity concerns, or changes in the Teleworker's eligibility to telework.

    a. Requests to end the telework arrangement must go through the manager of the Teleworker and be approved by HR.

3. As needed, the Teleworker's manager, in collaboration with HR, may evaluate changes to a Teleworker's job responsibilities and determine if continued participation in the telework program or return to the Central Worksite is appropriate.

J. Work Schedule and Accessibility

1. A Teleworker's schedule of work hours, including breaks, overtime, and deviations from regular work hours, should be approved by the Teleworker's manager.

    a. A manager shall take into consideration the overall impact of a Teleworker assignment to the department's service delivery, employee productivity, or the progress of individual or team assignments.

    b. A manager shall also take into consideration the overall impact of the Teleworker's total time outside of the Central Worksite. Considerations include, but are not limited to: meetings, consultations, presentations and conferences.

    c. CalOptima shall also give consideration to the overall effect of a Teleworker's and co-workers' schedules in maintaining adequate manager supervision and communication.

2. The number of hours normally scheduled to work by an employee shall not change because of telework.

3. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one alternative at a time.

4. Before working overtime, a non-exempt (hourly) Teleworker must receive his or her manager's written approval in advance.

5. An exempt Teleworker who plans to deviate from the Teleworker's regular work hours, including working beyond normal working hours and making up time, shall obtain his or her supervisor's approval in advance, where feasible.

6. Teleworkers will be required to complete their timecard electronically, consistent with employees at the Central Worksite.

7. Meal periods and breaks for a Teleworker will be consistent with those at the Central Worksite.

8. The Teleworker's manager should ensure that the Teleworker's schedule shall allow adequate time at the Central Worksite for meetings, access to facilities and supplies, and communication with other employees, providers or members.

9. When visiting the Central Worksite, a Teleworker will notify their direct supervisor or alternate of their presence in office building, including their physical location and tentative length of stay.

10. A Teleworker will attend job-related meetings, training sessions, and conferences, as requested by the manager. In addition, management may request a Teleworker to attend "short notice" meetings or to come into the Central Worksite for other CalOptima business related purposes. A Teleworker's manager will use telephone conference calling whenever possible as an alternative to requesting attendance at short notice meetings.

11. During telework hours, a Teleworker must be reachable via telephone, facsimile, office communicator, and/or e-mail during agreed-upon work hours or specific core hours of accessibility. The manager and Teleworker will agree on how to handle telephone messages, including the feasibility of call forwarding and frequency of checking telephone messages.

12. If the Central Worksite is closed due to an emergency or inclement weather, a Teleworker's manager will contact the Teleworker as soon as possible. A Teleworker may continue to work at the Remote Work Location. If there is an emergency at the Remote Work Location such as a power outage, a Teleworker will notify his or her manager as soon as possible. CalOptima may assign the Teleworker to the Central Worksite.

K. Dependent Care

1. A Teleworker will **not** act as a primary caregiver for dependent(s) during the agreed upon telework hours. Dependents may be present in the home during telework hours if care for the dependent will not require the Teleworker's attention. A Teleworker must make dependent care arrangements to permit concentration on performing work duties and responsibilities to the same extent as if he or she were performing work at the Central Worksite.

L. Deployment Preparation

1. All Teleworkers will complete mandatory pre-deployment documentation and telework orientation prior to final approval for telework deployment. Understanding the policies and procedures of telework is an important determinant of success in the telework program. Teleworkers may be required to complete additional educational or informational programs as deemed needed.

M. Telework Site/ Home Office

1. A Teleworker must maintain a suitable and secure designated workspace inside the Teleworker's residence that is clean, safe, and free from distractions.

   a. A Teleworker must set up a designated workspace as required by standards set by Environmental Health and Safety (EH&S) prior to beginning the Telework assignment.

   b. Preferably, this workspace will be a separate room that is designated as a home office.

   c. The home office location and specified workstation and internet access must be in compliance with the EH&S standards and the safety checklists.

d. The employee must sign and submit the CalOptima Teleworking Agreement, along with all other required documentation to HR within the required period of time.

2. A Teleworker will not hold face-to-face business meetings with providers, Members, or professional colleagues at the Home Office.

3. CalOptima may send agents of the organization to assist with equipment set-up in the Home Office.

   a. CalOptima will provide advanced notice of any delivery.

   b. The Teleworker must allow access to the Home Office at the designated day and time.

4. CalOptima will provide a predefined basic set of equipment as required for the Teleworker to perform his or her work duties.

5. All equipment that is provided initially for use at the telework site will be documented in the Telework Equipment Release Agreement.

   a. The Information Systems (IS) Department will maintain a list of CalOptima's equipment and software that is located in the Home Office Locations of Teleworkers.

6. If additional equipment or supplies are required related to Telework, the Teleworker must obtain prior approval for any additional costs.

   a. CalOptima will provide standard office supplies (i.e., pens, paper, and pencils).

   b. CalOptima shall not reimburse out-of-pocket expenses for supplies normally available at the Central Worksite.

7. Prior to beginning the telework program, a Teleworker will provide documentation of the workspace, in the form of current photograph, and must submit such documentation to the EH &S and HR departments.

8. Teleworkers are advised to consult with an insurance agent and/or tax consultant for information regarding their home office site. Individual tax implications, auto and homeowners' insurance, and incidental residential utility costs are the responsibility of the Teleworker.

N. Teleworker Performance Management

1. The manager and Teleworker will develop and agree upon any relevant goals and performance guidelines, as well as the frequency of performance discussions.

2. The manager of the Teleworker shall:

   a. Monitor the Teleworker's productivity and performance consistently and as business needs require.

   b. Provide timely and specific feedback to the Teleworker on a regular basis.

c. Plan for and use multiple channels to keep the Teleworker informed and up-to-date about departmental and CalOptima activities.

d. Remove a Teleworker from the program if the employee does not or continues to not meet the set performance standards.

O. Program Reporting and Evaluation

1. Teleworkers agree to monthly reporting and analyses, at a minimum, relating to his or her performance in order to evaluate the effectiveness of the Teleworker and telework program at CalOptima.

2. Each manager of one or more Teleworkers shall be required to provide documentation of goals, performance standards and outcomes for the Teleworkers to HR upon request.

P. Liability

1. A Teleworker is responsible for ensuring the safety of his or her Remote Work Location or alternative work environment.

2. A Teleworker will agree to a safety inspection and photographic documentation of the Telework Remote Work Location site to comply with workers' compensation liabilities, as well as comply with all items in the EH&S safety checklists.

3. Because liability may arise from hazards in the Remote Work Location that might cause serious harm or injury, CalOptima reserves the right to periodically inspect the Teleworker's Remote Work Location workspace. CalOptima will precede any such inspection by advanced notice and will schedule an appointment.

4. All ergonomic issues must be reported to the EH&S department. It is the responsibility of a Teleworker to notify EH&S early of any potential ergonomic issues in the home office workspace in the Remote Work Location.

5. CalOptima is not liable for any incident or accident that occurs outside of normal job-related activities or hours.

6. In the event of a job-related incident or accident during telework hours, a Teleworker must immediately report the incident to his or her manager.

a. A Teleworker, manager, and CalOptima must follow the policies regarding the reporting of injuries for employees injured while at work.

7. CalOptima is not responsible for any injuries to family members, visitors, and others in a Teleworker's Remote Work Location workspace.

8. CalOptima is not responsible for any loss or damage to:

a. A Teleworker's property;

b. Personal property owned by a Teleworker or any of the Teleworker's family members; or

c. Property of others in the custody of a Teleworker.

9. A Teleworker is responsible for contacting his or her insurance agent and a tax consultant and consulting local ordinances for information regarding Remote Work Location workplaces.

Q. Compliance: Handling PHI from a Remote Work Location

1. The same precautions governing the treatment of PHI at the Central Worksite shall apply to the Remote Work Location.

2. A Teleworker shall not leave documents including, but not limited to (electronic and/or hard copies): assessment forms, prior authorization, or other data collection forms unattended in areas accessible by unauthorized persons.

a. If PHI is being accessed by the Teleworker, when the Teleworker leaves the Remote Work Location or workspace, all paper PHI shall be stowed in a locked drawer designated for such storage. The Teleworker shall remain in possession of the key.

3. A Teleworker shall protect all documents that contain Member PHI from the view or access by unauthorized persons during transport to and from the Central Worksite through the use of:

a. Binders; or

b. Folders or other protective cover.

4. Upon their disposal, a Teleworker shall shred all PHI documents or files. A Teleworker shall transport PHI documents that are taken to the Remote Work Location and ready for destruction back to the Central Worksite for shredding.

5. A Teleworker shall immediately report any security incidents or compromised PHI to the Office of Compliance, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI and contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

R. Use of Computer from Remote Work Location

1. CalOptima will provide a Teleworker with a CalOptima personal computer (PC) or, with the approval of IS Infrastructure Management in certain circumstances, a laptop computer (laptop), and grant access to the CalOptima network.

2. A Teleworker shall adhere to the following information security procedures:

a. Maintain the confidentiality of his or her user sign-on identification code and password;

b. Keep the PC or laptop secure at all times;

c. Log off the VPN network when the PC or laptop will be left inactive or unattended, including but not limited to, during breaks, lunch periods, and at the end of the workday;

d. Ensure that passwords or operating instructions are not stored with the computer; and

e. Ensure that any issues with CalOptima equipment or systems are referred to the Help Desk for assistance, and that no unauthorized persons, or organizations, provide technical support for any CalOptima equipment or systems.

3. A Teleworker shall report any security incidents to the CalOptima Help Desk including, but not limited to:

a. Loss of a PC or laptop;

b. Software irregularities indicating possible virus infection; and

c. Access by unauthorized persons.

4. Failure to comply with the requirements listed above will result in the termination of the employee's telework arrangement and may also include disciplinary action up to and including termination of employment.

5. In the event of security or PHI incidents, Teleworkers are required to cooperate in internal investigations, outside investigators, law enforcement, and/or criminal and/or civil prosecution, when applicable.

S. Use of electronic mail with PHI

1. Internal e-mail: E-mail sent within the secure virtual private network (VPN) CalOptima system may contain PHI that is limited to the use and disclosure of the minimum necessary data to complete the required message.

2. External e-mail: E-mail that is sent external to CalOptima via the open internet shall not contain PHI unless the e-mail is encrypted using the required encryption system and the recipient is authorized to receive it.

T. Use of printer from Remote Work Location

1. Teleworkers are not allowed to print anything work related to a home printer. All printing should be done at the Central Worksite when the Teleworker comes into the Central Worksite On rare circumstances, HR, the Compliance Officer, and the Chief Security Officer may make an exception to allow for a Teleworker to receive a printer for use at home, but only if the employee is not dealing with any PHI.

U. Security of CalOptima Assets

1. The Teleworker must take reasonable precautions to secure and prevent damage to equipment provided and delivered to the Remote Location Worksite.

2. CalOptima's equipment must only be used by the Teleworker and may not be used by other guests or individuals for personal use.

3. If property of CalOptima is stolen or damaged in a Teleworker's home, CalOptima will repair or replace the property at CalOptima's expense, provided there is no contributory negligence on the part of the Teleworker.

4. Upon termination of employment or the telework arrangement, voluntary or otherwise, the employee shall return all CalOptima property to CalOptima.

5. CalOptima may pursue recovery from a Teleworker for CalOptima property that is:

   a. Not returned at the conclusion of employment; or

   b. Deliberately, or through negligence, damaged, destroyed, or lost while in the Teleworker's control.

6. In case of injury, theft, loss, or liability related to telework, a Teleworker must allow agents of the organization to investigate and/or inspect the telework site. CalOptima shall provide reasonable notice of inspection and/or investigation to the Teleworker.

V. Travel Reimbursement

1. CalOptima will not reimburse mileage for Teleworkers who come into **the Central Worksite** from a local Remote Worksite Location.

2. CalOptima will reimburse mileage when a Teleworker is required by management to drive into the Central Worksite only if the employee is required to travel two hundred fifty (250) or more miles one-way.

3. For off-site visits from the Teleworker's home, CalOptima shall base reimbursement for use of privately owned vehicles on actual mileage, to the nearest mile, less the number of miles required to drive from the Teleworker's residence to the Central Worksite, and back again, on a single day and in accordance with CalOptima GA.5004: Travel Policy.

4. Reimbursement shall be made at the mileage rate currently in effect for CalOptima, and in accordance with CalOptima GA.5004: Travel Policy. Different requirements for travel may apply to out-of-state Teleworkers, in which they should receive prior approval from their department executive before such travel arrangements are made.

W. Other Remote Work arrangements

1. In certain cases, arrangements other than those defined in this policy may be negotiated between CalOptima management, HR, and the Teleworker. All policy deviations must be approved by HR and the Teleworker's executive.

X. Failure to comply with the requirements of this Policy or follow CalOptima's policies, rules and procedures may result in: termination of the employee's telework arrangement and/or disciplinary action, up to and including termination of the employee. Certain violations of this Policy, other

applicable CalOptima policies, and/or state and federal laws may also result in criminal or civil prosecution, where applicable.

III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

A. CalOptima Telework Agreement
B. CalOptima Occasional Off-site Work Agreement

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.5004: Travel Policy
C. CalOptima Policy GA.8000: Glossary of Terms
D. CalOptima Policy GA.8020: 9/80 Work Schedule
E. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 02/01/18: Regular Meeting of the CalOptima Board of Directors
B. 12/03/15: Regular Meeting of the CalOptima Board of Directors
C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
D. 06/06/13: Regular Meeting of the CalOptima Board of Directors
E. 03/01/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	03/01/2012	GA.8044	Telework Program	Administrative
Revised	06/06/2013	GA.8044	Telework Program	Administrative
Revised	05/01/2014	GA.8044	Telework Program	Administrative
Revised	12/03/2015	GA.8044	Telework Program	Administrative
Revised	02/01/2018	GA.8044	Telework Program	Administrative

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
Central Worksite	CalOptima's primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West or the PACE building.
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.
Home Office	A designated workspace within the Teleworker' residence.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. 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.
Remote Work Location	The Employee's Home Office or designated pre-approved work location.
Teleworker	An employee who meets CalOptima's Teleworker eligibility criteria and is approved to routinely work their regularly scheduled work hours from a Remote Work Location, unless business needs require otherwise.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020
Special Meeting of the CalOptima Board of Directors

Report Item
4. Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic

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

Recommended Actions
1. Ratify and authorize unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $80,327; and

2. Authorize amendments to contracts with medical consultants Tanya Dansky, M.D. and Peter Scheid, M.D., who are assisting with CalOptima's response to the coronavirus pandemic, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $48,000 to fund contract extensions through June 30, 2020.

Background
On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with other federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

At its April 2, 2020, meeting, the Board ratified unbudgeted expenditures for emergency purchases to support coronavirus mitigation strategies, including CalOptima's Temporary Telework process, in an amount not to exceed $915,000. Under a separate action, the Board also ratified contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., to assist with CalOptima's response to the coronavirus situation, and reallocated budgeted but unused funds of $20,000 from the Professional Fees budget to fund these contracts.

Discussion
Emergency Purchases Related to Coronavirus Pandemic
Staff recommends the Board ratify and authorize unbudgeted expenditures for the following emergency purchases related to the coronavirus pandemic:

Department	Description	Amount
PACE	Staff personal protective equipment	$30,110
	Member personal protective equipment	$4,734
Information Services	Remote printing, mailing for operational areas (i.e., UM, Claims, MLTSS, GARs)	$30,000
Facilities	Staff personal protective equipment	$11,905
	Gloves, disinfectant products	$578

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Department	Description	Amount
	Estimated expenses for disinfectant products through June 30, 2020 ($1,000/month)	$3,000
	Total	**$80,327**

CalOptima contracted with the existing vendors to ensure timely and efficient service, compatibility with existing equipment, and the protection and security of CalOptima's employees and members. Emergency purchases with contracted vendors were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Contract Extensions with Medical Consultants

Staff recommends extending contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., through June 30, 2020, in order to continue work related to coronavirus mitigation activities, including information review and dissemination, regulatory reporting, collaboration with state, county and local entities, and other support activities for the Chief Medical Officer, as needed. The additional cost for the contract extensions through June 30, 2020, is $48,000.

Fiscal Impact

The recommended actions to ratify and authorize unbudgeted expenditures related to coronavirus pandemic and extend contracts with medical consultants are unbudgeted items. An allocation of up to $128,327 from existing reserves will fund these actions.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members during the coronavirus pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

/s/ Richard Sanchez — *04/10/2020*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Tanya Dansky, M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid, M.D.	17 Calle Frutas	San Clemente	CA	92673

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact
David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions
1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)
One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

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Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

For 20200402 BOD Review Only

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

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D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

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i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

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2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

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in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, 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 Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

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1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group 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)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

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I. 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
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

For 20200402 BOD Review Only

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

For 2020 POD Review Only

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
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.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
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.
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.

For 2020

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

For 2020040 Preview Only

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

For 20200402 BOD Review Only

Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

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

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I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.*, encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

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G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

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a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, 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.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

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C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

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a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

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I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
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.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
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.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
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
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.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

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

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. **Data Architect**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

E-MAIL PSCHEID12@GMAIL.COM
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
(714) 227-4123 CELL
(949) 229-7684 FAX

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3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

E-MAIL PSCHEID12@GMAIL.COM
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
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(949) 229-7684 FAX

EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL.COM
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TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contacts
Ladan Khamseh, Chief Operating Officer, (714) 246-8400
Michael Herman, Director Information Services, (714) 246-8400

Recommended Actions
Authorize the reallocation of the following budgeted funds from Medi-Cal: Other Operating Expenses to fund the Informatica Data Masking Software Maintenance license fee through June 30, 2021:

1. $67,950 from the Cloud Government/Storage Subscription; and
2. $67,950 from the Computer Equipment.

Background/Discussion
A Request for Proposal (RFP) was competed in early 2019 for a Data Masking Software solution to limit exposure of Protected Health Information (PHI) from staff working in CalOptima's non-production applications. Informatica was selected as the vendor and the first phase of the Data Masking project was implemented in early 2020. The first year software license fee was funded from the Fiscal Year (FY) 2018-19 approved Capital Budget. However, the subsequent annual Software Maintenance license fee ($135,000) should have been transitioned to the Operating budget for the subsequent years and was inadvertently left out of the FY 2020-21 Operating Budget. To address this oversight, Management recommends reallocating funds from two other parts of the IS budget, specifically, Cloud Government/Storage Subscriptions, and Computer Equipment. To ensure that such oversights do not occur in the future, management is introducing a final step in the budget process with Vendor Management to ensure all contract agreements moving from capital to operating expenses are reviewed.

Reallocating the funds from the Cloud Government/Storage Subscription and the Computer Equipment budgets is expected to have minimal impact to CalOptima operations. The purpose of the Cloud Government/Storage Subscription budget of $500,000 is to support our migration of data storage to CalOptima's Microsoft Azure Government Cloud. Annually, staff includes additional budget dollars to continue to move more services to the Microsoft Azure Government Cloud to support and enhance CalOptima's Business Continuity and Disaster Recovery (DR) infrastructure. The proposed reduction of funds from this budget will shift some of the data file sharing migration into the following FY 2021-22 budget expenditures. The proposed reallocation of funds from this budget category will leave a remaining balance of $432,050. Management believes this amount will be sufficient to cover the current services in the Microsoft Azure Government Cloud, including service migrations planned for the current fiscal year.

The Computer Equipment budget of $600,000 is to be used to replace computer and printer equipment as it nears end of its useful life. The proposed reduction of funds in this budget category will delay the

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replacement of a small number of computers and printers into the following fiscal year, but this is not expected to have a material impact on operations. The proposed reallocation of funds from this budget will reduce available funding for Computer Equipment to $532,050.

Fiscal Impact

The fiscal impact for these recommended actions is budget neutral. As proposed, a reallocation of up to $135,900 that was approved in other categories as part of the CalOptima FY 2020-21 Operating Budget on June 4, 2020, will fund the Informatica Data Masking Software Maintenance license fee through June 30, 2021.

Rationale for Recommendation

To ensure that CalOptima's IT security infrastructure continues to allow for appropriate management of protected health information (PHI) within CalOptima's non-production applications, management recommends the proposed reallocation of operating expenditures.

Concurrence

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

Attachment

1. Entities Covered by this Recommended Board Action

/s/ Richard Sanchez *09/23/2020*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Informatica LLC	2100 Seaport Blvd	Redwood City	CA	94063
CDW	200 N. Milwaukee Avenue	Vernon Hills	IL	60061
Dell	One Dell Way	Round Rock	TX	78682
Integration Partners	12 Hartwell Ave	Lexington	MA	02421
Intelli-Flex/Telanet	17315 Studebaker Rd. Ste 332	Cerritos	CA	90703
Laserzone	2421 West 205th St. Suite D104	Torrance	CA	90502
Microsoft	One Microsoft Way	Redmond	WA	98052
Nth Generation	17055 Camino San Bernardo	San Diego	CA	92127
SHI International Corporation	290 Davidson Ave.	Somerset	NJ	08873

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Actions
Recommend authorizing the ratification of reapportionment of budgeted funds among capital expense categories for various information services capital projects.

Background/Discussion
CalOptima Policy GA.5003: Budget and Operations Forecasting includes provisions that delegate authority to the Chief Executive Officer (CEO) to make budget allocation changes within certain parameters. Pursuant to this policy, budget allocations between different capital expense categories for the Board-approved capital project (e.g., hardware, software and professional fees related to implementation for Information Systems) require Board approval. Management is looking into the options for the Board to consider delegating authority to the CEO to make budget expense category changes within certain parameters for Board-approved capital projects as Staff may not always have sufficient information at the time of budgeting to accurately estimate actual costs by expense category within a particular project.

The CalOptima FY 2020-21 Capital Budget was approved by the CalOptima Board of Directors on June 4, 2020. Information Systems represent $14.5 million of the total Capital Budget and were budgeted by asset categories. Staff included the best available information at the time of budgeting. During the procurement process performed in accordance with CalOptima Policy GA.5022, the quoted pricing from vendors did not fall within the Board-approved expense categories. Management recommends ratification of the reapportionment of budgeted funds among capital expense categories for the Information System capital projects summarized in the following table and detailed below:

Project Description	Hardware	Software	Professional Fee	Total Capital
Network - Business Partner VPN Upgrade				
Original Budget	$160,000	$0	$0	$160,000
Reapportionment	($69,700)	$21,200	$48,500	$0
Revised Budget	$90,300	$21,200	$48,500	$160,000
CalOptima Internal Network Firewall Protection Server Upgrade				
Original Budget	$150,000	$0	$0	$150,000
Reapportionment	($68,900)	$45,900	$23,000	$0
Revised Budget	$81,100	$45,900	$23,000	$150,000

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Project Description	Hardware	Software	Professional Fee	Total Capital
Internet Firewall Protection Server Upgrade				
Original Budget	$450,000	$0	$0	$450,000
Reapportionment	($217,800)	$100,700	$117,100	$0
Revised Budget	$232,200	$100,700	$117,100	$450,000
Provider Portal Referral Documentation File Server Infrastructure				
Original Budget	$550,000	$35,000	$60,000	$645,000
Reapportionment	($100,000)	$100,000	$0	$0
Revised Budget	$450,000	$135,000	$60,000	$645,000
Remote Work Secure Connection Token Upgrade				
Original Budget	$93,000	$0	$0	$93,000
Reapportionment	($33,000)	$13,000	$20,000	$0
Revised Budget	$60,000	$13,000	$20,000	$93,000
Data Warehouse Analysis by Business				
Original Budget				
Reapportionment	$60,000	$0	$0	$60,000
Revised Budget	($3,065)	$990	$2,075	$0
	$56,935	$990	$2,075	$60,000

Fiscal Impact

The fiscal impact for the recommended action is budget neutral. If further budget reapportionment or reallocation changes are needed before the completion of the capital projects, Management will return to the Board to request authorization.

Rationale for Recommendation

Staff recommends approval of the recommended action as a budget-neutral way to better align budgeted funds with anticipated expenditures on Capital Projects in accordance with the CalOptima Policy: GA.5003 Budget and Operations Forecasting.

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

Attachments
1. FY 2020-21 Capital Attachment A
2. CalOptima Policy GA.5003 Budget and Operations Forecasting

/s/ Richard Sanchez *09/23/2020*
Authorized Signature **Date**

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Attachment A

Fiscal Year 2020-21 Capital Budget by Project

INFRASTRUCTURE	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Internet Firewall Protection Server Upgrade	450,000			450,000
505 Building Wireless System Upgrade	430,000			430,000
New IT Asset Management Application	100,000	150,000	50,000	300,000
User Identity and Access Management Application	70,000		200,000	270,000
Core Operational Server Upgrade (Blade Servers)	200,000			200,000
Business Partner End to End Virtual Private Network Upgrade	160,000			160,000
CalOptima Internal Network Firewall Protection Server Upgrade	150,000			150,000
Remote Work Secure Connection Token Upgrade	93,000			93,000
Data Warehouse Disk Storage Array Upgrade and Replacement	54,000			54,000
Call Center Telephony Upgrade	25,000	25,000		50,000
PACE Network Router Replacement	19,000			19,000
Storage Area Network Switch Ports Expansion	13,000			13,000
Virtual Machine VM Blade Switch Enclosures Upgrade	9,000			9,000
TOTAL INFRASTRUCTURE	**$ 1,773,000**	**$ 175,000**	**$ 250,000**	**$ 2,198,000**

APPLICATIONS MANAGEMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
CMS Interoperability and Patient Access System Implementation	250,000	1,750,000	500,000	2,500,000
Care Management System Implementation	250,000	1,500,000	500,000	2,250,000
Core Administration System Enhancement	125,000	1,150,000	500,000	1,775,000
Claims Pricer Integration Software		1,000,000	200,000	1,200,000
Provider Data Management Solution	250,000	750,000	125,000	1,125,000
Claims Payment Automation System Upgrade		450,000	100,000	550,000
Managed Care Predictive Analytics and Data Modeling		400,000	100,000	500,000
Hardware Upgrade for Computer Robotic Workflow	200,000			200,000
Provider Credentialing Integration to the Core Administration System	70,000		100,000	170,000
Additional Memory, CPU and Disc Space	50,000			50,000
Additional Storage Server Equipment	50,000			50,000
TOTAL APPLICATIONS MANAGEMENT	**$ 1,245,000**	**$ 7,000,000**	**$ 2,125,000**	**$ 10,370,000**

APPLICATIONS DEVELOPMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Provider Portal Referral Documentation File Server Infrastructure	550,000	35,000	60,000	645,000
CalOptima.org Web Content Management Server Upgrade	125,000	100,000	200,000	425,000
Litigation Hold and Discovery Applications		350,000		350,000
Enterprise Content Management System Consultation and Build			200,000	200,000
Data Governance and Meta Data Management Enhancement	60,000	50,000	24,000	134,000
Hardware to Support Portal Security Audit Reporting	60,000			60,000
Hardware to Support Financial HIPAA X12 Data Analysis	60,000			60,000
Application Development Source Code Foundation Server Replacement	10,000	9,000	20,000	39,000
TOTAL APPLICATIONS DEVELOPMENT	**$ 865,000**	**$ 544,000**	**$ 504,000**	**$ 1,913,000**

505 BUILDING IMPROVEMENTS	BUILDING	EQUIPMENT	PROFESSIONAL FEES	TOTAL CAPITAL
Office Renovations (Cubicle Reconfigurations)	380,000		35,000	415,000
Multiple Bathroom Upgrades (Original Bathrooms on 2nd and 4th Floors)	300,000		75,000	375,000
Lobby Security Improvements (Safety Barrier and Customer Service Room Reconfiguration)	250,000		50,000	300,000
1st Floor Conference Rooms Audio Visual System Upgrade	110,000		25,000	135,000
Cooling Tower Continuation	80,000			80,000
Copier Replacements and Lease	75,000			75,000
Sink Heating Installation for Restrooms Floors 5-10	50,000			50,000
Conference Rooms Audio Visual System Upgrade (5th and 9th Floors)	37,000		5,000	42,000
Ground Floor Corridor Heating and Cooling Boxes Replacement	35,000			35,000
IDF Room HVAC Continuation	20,000		5,000	25,000
Ceiling Replacement in Passenger Elevators	25,000			25,000
Building Security Cameras Upgrade	22,000			22,000
1st Floor Card Reader Addition	20,000			20,000
Replacement of Trash Room Double Doors with Fire Rated Doors	15,000			15,000
Domestic Water Circulation Pump Replacement	12,000			12,000
Recording Studio	10,000			10,000
TOTAL 505 BUILDING IMPROVEMENTS	**$ 1,441,000**	**$ -**	**$ 195,000**	**$ 1,636,000**

PACE	EQUIPMENT		PROFESSIONAL FEES	TOTAL CAPITAL
Workspace Efficiency and Expansion	57,000	-	-	$57,000
Rehab Equipment	15,000	-	-	$15,000
Audiovisual and Conference Room	12,000	-	-	$12,000
Lobby Refurbishment	10,000	-	-	$10,000
Clinic Doors Handicap Access	7,000	-	-	$7,000
Internal Staff Communication	6,000	-	-	$6,000
Clinic Spirometer	5,000	-	-	$5,000
Commercial Freezer	5,000	-	-	$5,000
Exterior Electricity	2,000	-	-	$2,000
TOTAL PACE	**$ 119,000**	**$ -**	**$ -**	**$ 119,000**

TOTAL FY 2020-21 CAPITAL BUDGET	**$ 5,443,000**	**$ 7,719,000**	**$ 3,074,000**	**$ 16,236,000**

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Policy #: GA.5003
Title: **Budget and Operations Forecasting**
Dept.: Finance
Section: Not Applicable
CEO Approval: Michael Schrader _MS_
Effective Date: 1/1/10
Last Review Date: 03/01/12
Last Revised Date: 03/01/12

I. PURPOSE

This policy describes the budget and operations forecasting process agency-wide and for all lines of business.

II. POLICY

A. CalOptima shall develop a yearly operating budget for each line of business and the consolidated agency.

B. CalOptima shall prepare a yearly capital budget for the purchase of Fixed Assets.

C. The development of all budgets shall reflect CalOptima's short and long-term strategic objectives.

D. CalOptima's Board of Directors shall approve all budgets.

E. CalOptima shall compare financial results to the operating budget each month as part of the monthly financial report to the Board of Directors.

F. CalOptima shall reforecast revenue and expenditures periodically throughout the year.

III. PROCEDURE

A. Operating and Capital Budgets

1. CalOptima's Finance Department, in collaboration with other departments, shall develop an operating budget for each Line of Business and agency-wide, on an annual basis.

2. CalOptima's Finance Department, in collaboration with other departments, shall develop an agency-wide capital budget, on an annual basis.

3. CalOptima's Finance Department shall reference the Annual Operational Plan for strategic guidance in the development of operating and capital budgets.

4. Presentation of Proposed Budgets to the Finance and Audit Committee of the Board of Directors

   a. CalOptima's Chief Financial Officer (CFO) or Designee shall present the proposed operating budget to the Finance and Audit Committee of the Board of Directors. The report shall include discussion of major assumptions and a comparison with the current year forecast.

b. CalOptima's CFO or Designee shall present the proposed capital budget by major asset type (e.g., hardware, software, tenant improvements, equipment). The report shall reference the Depreciation expense impact.

c. The Finance and Audit Committee of the Board of Directors shall review and approve the proposed budgets and propose changes, as necessary.

d. The Finance Department shall analyze the Finance and Audit Committee's proposed changes, and incorporate such changes, as necessary.

5. After the Finance and Audit Committee of the Board of Directors approves the proposed operating and capital budgets, CalOptima's CFO or Designee shall present the proposed budgets to the Board of Directors prior to beginning of each fiscal year.

6. The Board of Directors shall approve all budgets prior to implementation.

7. If unknown assumptions are utilized in the development of budgets (e.g. state program funding, rates), the Board of Directors may approve an interim budget to ensure that CalOptima has conditional appropriation funding. The Finance Department shall propose a revised budget when funding and rate information is confirmed.

8. CalOptima shall make all reasonable efforts to present proposed budgets for approval prior to the beginning of each fiscal year. In the case that CalOptima is unable to present proposed budgets prior to the beginning of the fiscal year, the CFO or Chief Executive Officer (CEO) shall request extension of the current year budget into the new fiscal year as a temporary measure, until key information is available.

B. Budget Allocation Changes

1. Medical Services. To the extent that there are unexpended budgeted funds approved for a specific supplemental program in the medical services budget (e.g., quality incentive programs), the CEO may make a budget substitution under a cumulative one hundred thousand dollars ($100,000) into or out of any supplemental program under the Medical Services Budget, subject to the conditions and limitations set forth below. Any budget substitution of one hundred thousand dollars ($100,000) or more is subject to the approval of the Board. Payments for supplemental programs are not for base rate payments (e.g. per diems, capitation rate, etc.) but are targeted to address a specific need or activity (quality incentives, incentive grants, etc.). Substitutions the CEO may make shall be:

a. For a program or activity that has been explicitly approved by the Board;

b. Limited to the same line of business, e.g., OneCare expenditure cannot be moved to Medi-Cal;

c. Budget neutral in the context of the Medical Services Budget for the line of business, which establishes targets or estimates of the provider payment portion of the overall Budget; and

d. Reported monthly to the Board as part of the Financial Report and reported to the Finance and Audit Committee with analysis on a quarterly basis.

2. Capital Budget. The CEO may make a substitution of a capital item for a different capital item under one hundred thousand dollars ($100,000) in the approved Capital Budget subject to the conditions and limitations set forth below. Any budget substitution of one hundred thousand dollars ($100,000) or more is subject to the approval of the Board. Substitutions the CEO may make shall be:

    a. For a program or activity that has been explicitly approved by the Board;

    b. Budget neutral in the overall Capital Budget;

    c. Reported monthly to the Board as part of the Financial Report and reported to the Finance and Audit Committee with analysis on a quarterly basis; and

    d. Within the same capital expense category, which for purposes of the Capital Budget shall be defined as follows:

        i. Information Systems Hardware;

        ii. Information Systems Software, or

        iii. Furniture, Fixtures and Equipment (FF&E).

3. Administrative Budget. The CEO may make a substitution of an administrative expense up to but less than one hundred thousand dollars ($100,000) in the approved Administrative Budget for another subject to the conditions and limitations below. Any budget substitution of one hundred thousand dollars ($100,000) or more is subject to the approval of the Board. Examples of programs or activities would be: ICD-10, National Committee on Quality Assurance (NCQA), MSI Transition, Health Care Reform analysis, Long-Term Care Integration, Behavioral Health integration, etc. These are in addition to maintenance of business for CalOptima's existing lines of business. The administrative portion of the Medical Services Budget (i.e., expenses for medical management, utilization management, etc.) shall have the same substitutions policy as outlined above for the Administrative Budget. Substitutions the CEO may make shall be:

    a. For a program or activity that has been explicitly approved by the Board;

    b. Limited to the same line of business, e.g., OneCare expenditure cannot be moved to Medi-Cal;

    c. Budget neutral in the context of the Administrative Budget; and

    d. Reported monthly to the Board as part of the Financial Report and reported to the Finance and Audit Committee with analysis on a quarterly basis.

4. No changes in the budget exceeding one hundred thousand dollars ($100,000), or that would provide funding for a program or activity not approved by the Board, may be made without the prior approval of the Board of Directors.

C. Reporting and Analysis

1. On a monthly basis, CalOptima's Accounting and Finance Department shall prepare the following standard financial reports for internal presentation to the CalOptima Executive Officers and at the Board of Directors meeting:

   a. Financial highlights;

   b. Enrollment summary and trend;

   c. Balance Sheet;

   d. Income Statement; and

   e. Statement of Cash Flows.

2. CalOptima's Finance Department shall compare actual capital spending against the budget on a monthly basis and shall report the results quarterly to the Finance and Audit Committee of the Board of Directors.

3. CalOptima's Accounting and Finance Departments may present additional financial reports and updates to the Finance and Audit Committee of the Board of Directors and other associated committees, as necessary.

D. Re-forecasting

1. CalOptima's Finance Department shall prepare periodic re-forecasts of the current fiscal year by line of business for internal review.

2. If there are significant changes due to enrollment, rates, revenue, or expenses, CalOptima's CFO or Designee shall report this information to the Finance and Audit Committee of the Board of Directors and Board of Directors.

3. CalOptima's Finance Department may perform forecasts and re-forecasts for the upcoming two (2) to three (3) years, both for internal planning and discussion with the Board of Directors and other associated committees.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 03/01/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Effective	01/01/2010	GA.5003	Budget and Operations Forecasting
Revised	03/01/2012	GA.5003	Budget and Operations Forecasting

IX. GLOSSARY

Term	Definition
Operating Budget	Expenses associated with maintenance of business.
Asset	A tangible or intangible item of value.
Capital Budget	Amounts spent to acquire or improve a long-term asset such as equipment or Buildings.
Depreciation	An expense recorded to allocate a tangible Asset's Cost over its useful life
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.
Fixed Assets	Fixed Assets or capital Assets are tangible Assets with a value greater than or equal to the Capitalization Threshold and a useful life in excess of one (1) year. Fixed Assets include Buildings, machinery and equipment, computer equipment, vehicles, Improvements, and Land.
Medical Services Budget	Expenses associated with providing care for members
Member	An Enrollee-beneficiary of a CalOptima program.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Brigette Gibb, Executive Director, Human Resources, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental, and vision for CalOptima employees and eligible retirees (and their dependents), and basic life, accidental death and dismemberment, short-term disability (STD) and long-term disability (LTD) insurance, an employee assistance program, and flexible spending accounts for Calendar Year (CY) 2021 in an amount not to exceed $23 million which includes the following proposed changes:

    a. A decrease in employer contributions (based on the percentage of premium the employer pays for each plan), as a result of a 6.6% reduction in premium rates, reducing costs to CalOptima for CY 2021 in an amount of $1,444,451;

    b. The addition of a new option for the Cigna HealthCare (Cigna) HMO medical plan (Select Network) offered alongside the current full network Cigna HMO plan for active employees and eligible retirees with reduced premiums, which could result in an estimated cost savings of as much as $367,464 if employees select this plan over those with more expensive employee contribution rates;

    c. An increase in employee contributions at each tier level for the current full network Cigna HMO plan to mirror the same employee contribution schedule as the Kaiser HMO medical plan;

    d. A continuation of employer contributions for CY 2021 in an estimated amount of $182,500 to fund the Health Savings Accounts (HSA) monthly for employees currently enrolled in the Cigna High Deductible Health Plan (HDHP);

2. Authorize the acceptance of the premium holiday in the amount of $125,000 received from Cigna Healthcare (Cigna); and

3. Authorize the receipt and expenditures for CalOptima staff wellness programs from $25,000 in funding received from the Cigna Wellness/Health Improvement Fund for CY 2021.

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Background

California Government Code section 53201 provides that local public agencies, including CalOptima, have the option of providing health and welfare benefits for the benefit of their officers, employees, and retired employees who elect to accept the benefits and who authorize the local agencies to deduct the premiums, dues, or other charges from their compensation. Government Code section 53200 provides that health and welfare benefits may include hospital, medical, surgical, dental, disability, group life, legal expense, and income protection insurance or benefits. While CalOptima previously contracted with the California Public Employees Retirement System (CalPERS) to provide these benefits, on August 5, 2003, the Board approved the cancellation of CalOptima's contract with CalPERS for employee health insurance coverage effective January 1, 2004 and opted to contract directly with Aetna and Kaiser for plan year 2004. CalOptima has offered such benefits from commercial insurers since that time, purchasing group health insurance through insurance brokers on a year-to-year basis. From April 2020 thru March 2023, CalOptima will be purchasing insurance through Alliant, an insurance broker. CalOptima currently contracts with both Kaiser and Cigna to provide group health insurance coverage for all benefited employees and qualifying retirees. CalOptima also contracts with AmWins to provide Medicare supplemental coverage for qualifying Medicare eligible retirees and their dependents.

By statute, the Board may authorize payment of all, or such portion as it may elect, of premiums for these health and welfare benefits. CalOptima currently pays a portion of the premiums for health and welfare benefits for officers, employees, and eligible retired employees, as well as their eligible dependents. In plan year 2015, there was no increase to the employee contributions because CalOptima received a rate decrease, which, in effect, decreased CalOptima's contributions towards the premiums. In plan year 2016, there was an increase in premium rates, and CalOptima shared in premium increases, paying a small portion and passing along the remaining increase to employees, averaging roughly a 3% to 4% increase to employee contributions for Kaiser HMO, Cigna HMO, Cigna HDHP, Cigna PPO and Cigna Dental PPO. In plan year 2017, there was an increase in premium rates of 2.3% or $321,608, and CalOptima absorbed this premium increase. In plan year 2018, there was an increase in premium rates averaging roughly 10%, and CalOptima and the employees shared in the costs of premium rate increases. In plan year 2019, there was a modest increase of 0.8% or $145,047 that CalOptima absorbed. In plan year 2020, there was an 8% increase in premium rates in the amount of $1,605,723, and CalOptima and employees shared in the additional costs.

Discussion

On behalf of CalOptima, Alliant negotiated for the renewal of CalOptima's health and welfare benefits which resulted in a gross decrease of 6.6% or $1,444,451 for CY 2021. Based on the recommendations below, CalOptima's share of the total group health and welfare benefits package will result in an annual net decrease of approximately 7.1% or $1,414,322 for CY 2021, with CalOptima's share of the premiums totaling approximately $18,450,819. The proposed change in premiums falls below the regional average, which is experiencing an increase ranging from 4% to 11%. The recommended changes are summarized below:

Benefit	CY 2020	CY 2021	Difference
Medical	$18,897,399	$17,583,863	($1,313,536)
Wellness Activities	$20,000	$25,000	$5,000

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Benefit	CY 2020	CY 2021	Difference
Dental Insurance	$1,576,027	$1,440,112	(135,915)
Vision Insurance	$193,043	$193,043	$0
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	$49,140	$49,140	$0
STD Insurance	$502,748	$502,748	$0
LTD Insurance	$229,798	$229,798	$0
Employee Assistance	$34,611	$34,611	$0
HSA	$182,500	$182,500	$0
Medical Stipends	$171,600	$171,600	$0
Total	**$21,856,866**	**$20,412,415**	**($1,444,451)**
CalOptima's Share	$19,865,141	$18,450,819	($1,414,322)
Employees' Share	$1,991,725	$1,961,596	($30,129)
Spousal Surcharge	($224,400)	($235,900)	($11,500)
Cigna Wellness Funding	($20,000)	($25,000)	($5,000)
Cigna Premium Holiday	$0	(125,000)	($125,000)

Additional details are provided by benefit plan for CY 2021 in Attachment A.

Medical

Cigna: Alliant negotiated down the initial renewal offer from Cigna of a 5.5% increase to a proposed decrease of 7.0% or $630,296 for active employees and eligible retirees. Additionally, staff is recommending that the Cigna Select HMO network plan be added in addition to the current Full Network Cigna HMO plan. Adding the Cigna Select HMO medical plan may further increase the savings to an estimated 11.1% or $997,760. Savings assumes that current Cigna HMO Full Network enrollees whose primary care providers are part of the Cigna HMO Select plan will migrate from the Full Network to the Select Network. Although the Cigna rates decreased, staff recommends increasing the Full Network Cigna HMO employee contribution rates to align with Kaiser's employee contribution rate schedule. Cigna has offered a $125,000 holiday premium (which will result in a $125,000 reduction in the premium for January).

Kaiser: Kaiser proposed a renewal decrease of 3.2% or $306,890 in premium reduction for employees and qualifying retirees. The Senior Advantage HMO Plan received a decrease of 10.8% or $8,850 in premium reduction. Staff recommends employee contribution rates remain the same.

AmWins PPO**:** AmWINS provides PPO Supplemental coverage to Medicare-eligible retirees and dependents. While AmWINS rates has not yet been released, staff recommends that the employee/retiree contribution rates remain the same level for 2021.

Wellness Funding: Cigna provides a Wellness/Health Improvement Fund to assist in improving the health and productivity of CalOptima's employees, focusing on behavior change and health status

improvement, and creating a health and wellness program strategy leading toward a culture of well-being. Each year, Cigna informs CalOptima of the amount of funds offered for the upcoming calendar year, and for CY 2021, the provided amount is $25,000. Cigna has specific guidelines regarding the types of events the Wellness/Health Improvement Fund can be used towards. The funds may be used to reimburse CalOptima for employee health and wellness program expenses, including but not limited to gym discount sponsorships, educational workshops, and employee wellness activities. Cigna also has specific guidelines by which proposed activities are approved and submitted for reimbursement.

For CY 2021, the proposed wellness activities recommended include:

2021 Wellness Program/Event/Activity	**Estimated Cost**
Wellness Programs (Walk Across America, Pick Your Challenge)	$5,000.00
Wellness Month (Wellness activities)	$10,000.00
Customer Service Week	$5,000.00
Health Education/Wellness Incentives	$5,000.00
Total	**$25,000.00**

Dental
Cigna Dental: Alliant negotiated an overall 8.7% or $136,435 decrease to premiums for both CalOptima employees and eligible retirees. Staff recommends no change to employee contribution rates, with CalOptima absorbing the savings.

Vision
VSP**:** Renewal came at no rate change due to a rate guarantee for 2021. Staff recommends no change to employee contributions.

Other Ancillary Plans
Cigna Life & Disability:

Basic Life/AD&D – Renewal came at no rate change due to a rate guarantee for 2021. Staff recommends no change to employee contribution rates.

Voluntary Life/AD&D: Renewal came at no rate change due to a rate guarantee for 2021. Staff recommends no change to employee contribution rates.

Cigna Short Term Disability (STD) and Long Term Disability: Renewal came at no rate change due to a rate guarantee for 2021.

Employee Assistance Program: Renewal came at no rate change due to a rate guarantee for 2021.

Health Savings Account
CalOptima offers a Health Savings Account for employees enrolled in the HDHP medical plan. CalOptima first started offering this medical plan in 2014 and funded the Health Savings Account 100% that same year as an incentive for employees to transition to the Cigna HDHP. The Cigna HDHP is more cost effective and offers the same or comparable benefits as the PPO plan CalOptima previously

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offered. As part of the benefits renewal last year, staff eliminated the more expensive PPO plan for employees and retirees who reside in California. To assist with a transition period away from the PPO medical plan to the Cigna HDHP medical plan, staff recommended that CalOptima fund the Health Savings Accounts for CY 2020 on January 1, 2020 for employees who elected the Cigna HDHP medical plan. This strategy was successful as it resulted in 96 employees who enrolled in the HDHP medical plan. For 2021, the PPO plan is limited to only employees residing outside of California; therefore, there is no longer a need to incentivize movement out of the PPO plan by; frontloading CalOptima's contribution; however, staff recommends CalOptima continue to partially fund the Health Savings Accounts monthly as a tool for attracting and retaining talent. Assuming all employees currently in the plan continue this coverage, the annual amount will be $182,500.

Medical Stipends
CalOptima offers a medical stipend of $100 per pay period (for 24 pay periods) as a cost saving measure to CalOptima and an incentive for employees who have medical coverage outside of CalOptima. Employees must submit proof of outside coverage in order to be eligible for this benefit.

Employer and Employee Contribution Comparison
CalOptima's and individual employee's share of healthcare premiums differ depending on the employee's elections. As set forth in the attached presentation, employer premium contributions for full time employees range from 76.7% to 96.8% and the premium contribution rates for employees and retirees range from 3.2% to 23.3%. The methodology used to calculate the employer and employee contributions is intended to aid management in attracting and retaining talented employees. CalOptima's group health benefits insurance is comparable to the County of Orange with an average of 89.6% employer contribution rate for CalOptima's employee only coverage, in comparison to the County's 90% employer contribution rate. However, CalOptima's employer contribution for employees with dependents is higher than the County of Orange at an average of 87.2% employer contribution rate compared to the County's 75% employer contribution rate.

Staff Recommendations
Except for the Cigna HMO plans, staff recommends no other changes to the employee/retiree contribution rates. The employee/retiree contribution rates for the Cigna HMO Full Network are proposed to be increased, depending on the tier selected, to align with the Kaiser rates; however, Cigna HMO Select is a new plan that will be offered to employees/retires at rates that are approximately half of what the Cigna HMO was offered at last year in order to incentivize employees to elect this new option. The proposed employee contribution strategy enables CalOptima to benefit from the reduced premium rates (decrease in CalOptima's costs from CY 2020 in an estimated amount at $1,414,322) while still offering employees and eligible retirees options with rates at the same or reduced amount from last year. This recommendation, along with the other recommended actions, are made based on a thorough review by CalOptima's Human Resources Department to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide a comprehensive benefits package to attract and retain talent.

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Fiscal Impact

The fiscal impact for group health insurance policies for CalOptima employees and retirees in CY 2021 is estimated at a total cost not to exceed $23.0 million. The recommended action to provide group health insurance policies for CalOptima employees and retirees for the period of January 1, 2021, through June 30, 2021, and associated anticipated expenditures are budgeted items in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Management will include funding for group health insurance policies for the period July 1, 2021 through December 31, 2021, in the CalOptima FY 2021-22 Operating Budget.

Concurrence

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

Attachment

A. CalOptima Presentation – January 2021 Renewal Meeting

/s/ Richard Sanchez *09/23/2020*
Authorized Signature **Date**

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Alliant

Executive Summary

CalOptima 2021 Renewal

Your partner in new possibilities.

Agenda

I. 2021 Renewal Recommendation
   i. Executive Summary
   ii. Financial Overview
   iii. Cigna Dual HMO Option
II. Recommended Contribution Strategies
   I. Medical Plans
   II. Ancillary Plans



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2021 Renewal Recommendations

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Executive Summary



Medical Renewal:

Cigna:

- The initial renewal action proposed by Cigna was **+5.5% or $497,012 in additional premium**. To mitigate this cost increase, CalOptima's new benefit consultant, Alliant, released a request for proposals covering the entire medical market. In response to the marketing results, after several rounds of negotiations, Cigna revised their renewal to a final **-7% decrease or $630,296 in savings.**
- As a renewal option, Cigna is proposing its Select HMO network in addition to the current Full Network. This renewal option will further increase the savings with an estimated **-11.1% decrease or $997,760 in savings***
- Both options include a second year rate cap of 12% on the Full HMO and PPO plans, 8% on the Select HMO plan, a $125,000 premium holiday (or optional service credit) and a $25,000 wellness fund.

Kaiser Permanente:

- The proposed renewal actions for the Active and Early Retiree HMO plans are a decrease of -**3.2% or $306,890 reduction in premium**. The Senior Advantage HMO Plan received a **-10.8% or $8,850 reduction** in premium.

AmWins:

- The AmWins Medicare renewal rates are scheduled to be released in early September.

Recommendation: Renew the current Cigna medical plan, implementing a narrow network HMO plan, in addition to the full network HMO. Renew the Kaiser and AmWins plans for another 12 months.

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Executive Summary



Dental Renewal:

Cigna

- The dental plans renewed level for 2021. To ensure competitive pricing, similar to the medical coverage, Alliant released a request for proposals covering the entire dental market. In the light of the marketing results, Cigna revised its initial renewal position and proposed a -8.8% decrease on the dental PPO plan, and -6% decrease on the dental HMO plan, for an overall renewal of **-8.7% decrease or $136,435 in savings.**

Recommendation: Renew the Cigna dental plans for another 12 months.

Vision Renewal:

- **VSP:** The VSP vision plan is currently in rate guarantee through 12/31/2021.

Recommendation: Renew with VSP for another 12 months.

Life and Disability Renewal:

- **Cigna:** The Cigna Basic Life, AD&D and LTD plans are in a rate guarantee through 12/31/2022, while the STD plan through 12/31/2021.

Recommendation: Renew the life and disability plans with Cigna through the expiration of the rate guarantees.

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Executive Summary



FSA & COBRA Administration:

- **WageWorks:** The FSA & COBRA plan administration fees are renewing level for the following plan year.

Recommendation: Renew the administration of these services with WageWorks for another 12 months.

Employee Assistance Program:

- **ACI:** The Employee Assistance Program is in a rate guarantee through 12/31/2022.

Recommendation: Renew the ACI for another 12 months.

Miscellaneous Recommendations:

- **Employer HSA Contribution:** CalOptima to fund the Health Savings Accounts for employees enrolled in the Cigna HDHP with up to an annual amount of $1,250 for single and $2,500 for family coverage, contributed on a monthly basis.
- **Medical Waiver Benefit:** keep the benefit amount level at $200 / month
- **Spousal Surcharge:** Keep the spousal surcharge amount at $100 / month

Financial Overview

Line of Coverage (Actives & Retirees)	EE's	Current Cost	Final Renewal Cost	% Change
Kaiser HMO - Actives	689	$9,467,320	$9,163,806	-3.2%
Kaiser HMO - Early Retirees	5	$106,354	$102,942	-3.2%
Kaiser - KPSA	20	$82,182	$73,332	-10.8%
AmWins Medicare	30	$237,892	*Renewal Pending* $237,892	0.0%
Cigna HMO - Actives & Early Retirees	411	$7,289,505	*Dual HMO Option* $6,411,735	-12.0%
Cigna OAP (OOS EE's Only)	4	$124,385	$115,678	-7.0%
Cigna HDHP	96	$1,589,761	$1,478,478	-7.0%
ER Funded HSA ($1,250 / $2,500)	96	$182,500	$182,500	0.0%
Cigna Dental PPO	1074	$1,473,522	$1,343,752	-8.8%
Cigna DHMO	272	$102,505	$96,360	-6.0%
VSP Vision	1340	$193,043	*Rate Guarantee* $193,043	0.0%
Cigna Basic Life AD&D	1340	$49,140	*Rate Guarantee* $49,140	0.0%
Cigna STD	1340	$502,748	*Rate Guarantee* $502,748	0.0%
Cigna LTD	1340	$229,798	*Rate Guarantee* $229,798	0.0%
ACI EAP	1317	$34,611	*Rate Guarantee* $34,611	0.0%
Waiving Medical Coverage	143	$171,600	$171,600	0.0%
TOTAL ANNUAL PREMIUM		**$21,836,866**	**$20,387,416**	
Cigna Premium Holiday / Optional Service Credit			*-$125,000*	
ADJUSTED ANNUAL PREMIUM		**$21,836,866**	**$20,262,416**	
ANNUAL DOLLAR CHANGE FROM CURRENT			**$1,574,451**	
ANNUAL PERCENTAGE CHANGE FROM CURRENT			**7.2%**	

NOTE: ER funded HSA assumes the same funding level as current. Medical waiver benefit amount remains the same. Future cost estimated based on current enrollment.

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Recommended Cigna Dual HMO Option

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Cigna Dual Option HMO Plan

Medical Plan Benefits	Cigna HMO - Actives & Early Retirees Current / Renewal	Dual HMO Option: Cigna Full HMO Option	Dual HMO Option: Cigna Select HMO Option
Calendar Year Deductible Individual / Family	None	None	None
Annual Out-of-Pocket Maximum Individual / Family	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $3,000
Physician Office Visit	$20	$20	$20
Specialist Copay	$30	$30	$30
Preventative Care	No Charge	No Charge	No Charge
Lab and X-Ray CT, MRI, PET scans Other lab and x-ray tests	 No Charge No Charge	 No Charge No Charge	 No Charge No Charge
Hospitalization Inpatient Outpatient	 $250 per admission $125 per visit	 $250 per admission $125 per visit	 $250 per admission $125 per visit
Emergency Room	$100 (waived if admitted)	$100 (waived if admitted)	$100 (waived if admitted)
Urgent Care Services	$50	$50	$50
Durable Medical Equipment	No Charge	No Charge	No Charge
PRESCRIPTION DRUGS	Generic / Brand / Non- Formulary	Generic / Brand / Non- Formulary	Generic / Brand / Non- Formulary
Rx Out of Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Retail - 30 day supply Mail Order - up to 100 day supply	$15 / $30 / $50 $30 / $60 / $100	$15 / $30 / $50 $30 / $60 / $100	$15 / $30 / $50 $30 / $60 / $100

MONTHLY RATES	Total	Current	Initial Renewal	Final Renewal	Total	Option	Total	Option
EE Only	128	$705.66	$744.46	$656.26	64	$650.05	64	$591.55
EE + Spouse	43	$1,544.15	$1,629.05	$1,436.06	21	$1,422.47	22	$1,294.45
EE + Child(ren)	97	$1,394.72	$1,471.41	$1,297.09	49	$1,284.82	48	$1,169.18
EE + Family	143	$2,205.93	$2,327.23	$2,051.51	71	$2,032.10	72	$1,849.21
	411				205		206	
MONTHLY PREMIUM		**$607,459**	**$640,861**	**$564,936**		**$278,710**		**$255,601**
ANNUAL PREMIUM		**$7,289,505**	**$7,690,328**	**$6,779,226**		**$3,344,524**		**$3,067,210**
ANNUAL DOLLAR CHANGE			**$400,823**	**-$510,279**		**-$877,771**		
ANNUAL PERCENT CHANGE			**5.5%**	**-7.0%**		**-12.0%**		

Enrollment as of 2021 Cigna Renewal

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

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Recommended Employer Contributions

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Recommended Employer Contributions – Medical Plans

Medical Plans		Current 2020 Contributions					2021 Contributions Cigna Dual HMO Option				
		Total	ER Cost	EE Cost	EE %		Total	ER Cost	EE Cost	EE %	EE Cont.
Kaiser HMO - Actives	Lives					Lives					
EE Only	254	$585.70	$527.13	$58.57	10.0%	254	$566.93	$508.36	$58.57	10.3%	$0.00
EE + Spouse	91	$1,171.40	$1,054.26	$117.14	10.0%	91	$1,133.86	$1,016.72	$117.14	10.3%	$0.00
EE + Child(ren)	146	$1,112.84	$1,001.56	$111.28	10.0%	146	$1,077.16	$965.88	$111.28	10.3%	$0.00
EE + Family	198	$1,874.26	$1,686.83	$187.43	10.0%	198	$1,814.16	$1,626.73	$187.43	10.3%	$0.00
Annual Premium	**689**	$9,467,320	$8,520,585	$946,734		**689**	$9,163,806	$8,217,072	$946,734		
Kaiser HMO - Early Retirees											
EE Only	1	$877.51	$818.94	$58.57	6.7%	1	$849.36	$790.79	$58.57	6.9%	$0.00
EE + Spouse	2	$1,755.02	$1,637.88	$117.14	6.7%	2	$1,698.72	$1,581.58	$117.14	6.9%	$0.00
EE + Child(ren)	1	$1,667.27	$1,555.99	$111.28	6.7%	1	$1,613.78	$1,502.50	$111.28	6.9%	$0.00
EE + Family	1	$2,808.04	$2,620.61	$187.43	6.7%	1	$2,717.94	$2,530.51	$187.43	6.9%	$0.00
Annual Premium	**5**	$106,354	$99,256	$7,099		**5**	$102,942	$95,844	$7,099		
Cigna HMO - Actives & Early Retirees											
EE Only	128	$705.66	$668.23	$37.43	5.3%	64	$650.05	$591.48	$58.57	9.0%	$21.14
EE + Spouse	43	$1,544.15	$1,449.68	$94.47	6.1%	21	$1,422.47	$1,305.33	$117.14	8.2%	$22.67
EE + Child(ren)	97	$1,394.72	$1,309.38	$85.34	6.1%	49	$1,284.82	$1,173.54	$111.28	8.7%	$25.95
EE + Family	143	$2,205.93	$2,069.17	$136.76	6.2%	71	$2,032.10	$1,844.67	$187.43	9.2%	$50.66
Annual Premium	**411**	$7,289,505	$6,849,252	$440,254		**205**	$3,344,524	$3,044,901	$299,623		
Cigna Select HMO - Actives & Early Retirees											
EE Only	0					64	$591.55	$572.83	$18.72	3.2%	-$18.72
EE + Spouse	0					22	$1,294.45	$1,247.21	$47.24	3.6%	-$47.24
EE + Child(ren)	0	N/A				48	$1,169.18	$1,126.51	$42.67	3.6%	-$42.67
EE + Family	0					72	$1,849.21	$1,780.83	$68.38	3.7%	-$68.38
Annual Premium	**0**					**206**	$3,067,210	$2,956,709	$110,501		
Cigna OAP (OOS EE's Only)											
EE Only	1	$1,131.90	$931.78	$200.12	17.7%	1	$1,052.67	$852.55	$200.12	19.0%	$0.00
EE + Spouse	0	$2,452.10	$1,975.61	$476.49	19.4%	0	$2,280.45	$1,803.96	$476.49	20.9%	$0.00
EE + Child(ren)	1	$2,217.87	$1,786.90	$430.97	19.4%	1	$2,062.62	$1,631.65	$430.97	20.9%	$0.00
EE + Family	2	$3,507.84	$2,793.08	$714.76	20.4%	2	$3,262.29	$2,547.53	$714.76	21.9%	$0.00
Annual Premium	**4**	$124,385	$99,658	$24,727		**4**	$115,678	$90,951	$24,727		
Cigna HDHP Actives & Early Retirees											
EE Only	46	$813.26	$709.61	$103.65	12.7%	46	$756.33	$652.68	$103.65	13.7%	$0.00
EE + Spouse	16	$1,707.85	$1,415.47	$292.38	17.1%	16	$1,588.30	$1,295.92	$292.38	18.4%	$0.00
EE + Child(ren)	17	$1,545.19	$1,280.65	$264.54	17.1%	17	$1,437.03	$1,172.49	$264.54	18.4%	$0.00
EE + Family	17	$2,439.78	$1,911.11	$528.67	21.7%	17	$2,269.00	$1,740.33	$528.67	23.3%	$0.00
Annual Premium	**96**	$1,589,761	$1,314,596	$275,164		**96**	$1,478,478	$1,203,314	$275,164		
Kaiser Sr. Advantage HMO - Medicare Retirees											
EE Only on Medicare	9	$220.92	$198.83	$22.09	10.0%	9	$197.13	$175.04	$22.09	11.2%	$0.00
EE + Spouse both on Medicare	11	$441.84	$397.66	$44.18	10.0%	11	$394.26	$350.08	$44.18	11.2%	$0.00
Annual Premium	**20**	$82,182	$73,964	$8,218		**20**	$73,332	$65,114	$8,218		
AmWins - Medicare Retirees (Renewal Pending)											
EE Only on Medicare	15	$440.54	$362.53	$78.01	17.7%	15	$440.54	$362.53	$78.01	17.7%	$0.00
EE + Spouse both on Medicare	15	$881.08	$704.18	$176.90	20.1%	15	$881.08	$704.18	$176.90	20.1%	$0.00
Annual Premium	**30**	$237,892	$192,008	$45,883		**30**	$237,892	$192,008	$45,883		
MEDICAL TOTAL		**$18,897,399**	**$17,149,319**	**$1,748,080**	**9.3%**		**$17,583,863**	**$15,865,913**	**$1,717,951**	**9.8%**	
DOLLAR CHANGE FROM CURRENT							**-$1,313,536**	**-$1,283,406**	**-$30,130**		
PERCENT CHANGE FROM CURRENT							**-7.0%**	**-7.5%**	**-1.7%**		

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Recommendations:

- **Kaiser HMO Actives & Early Retirees**: Keep the current employee contributions level for 2021
- **Cigna Full HMO (Actives & Early Retirees):** Increase the current employee contributions to match the Kaiser HMO plan.
- **Cigna Select HMO (Actives & Early Retirees)**: Set the employee contribution level at 50% of the current Cigna Full HMO plan. This will drive enrollment and provide savings for both employees and employer.
- **Cigna OAP PPO (OOS Employees)** : Keep the current employee contributions level for 2021
- **Cigna HDHP (Actives & Early Retirees):** Keep the current employee contributions level for 2021
- **Kaiser Sr. Advantage & AmWins (Medicare Retirees)** Keep the current employee contributions level for 2021

Recommended Employer Contributions – Ancillary

Ancillary Plans		Current 2020 Contributions				2021 Contributions Cigna Dual HMO Option				
		Total	ER Cost	EE Cost	EE %	Total	ER Cost	EE Cost	EE %	EE Cont.
Cigna Dental PPO	Lives									
EE Only	374	$49.47	$44.27	$5.20	10.5%	$45.11	$39.91	$5.20	11.5%	$0.00
EE + Spouse	188	$98.28	$82.56	$15.72	16.0%	$89.63	$73.91	$15.72	17.5%	$0.00
EE + Child(ren)	185	$126.26	$106.06	$20.20	16.0%	$115.14	$94.94	$20.20	17.5%	$0.00
EE + Family	327	$191.00	$159.46	$31.54	16.5%	$174.18	$142.64	$31.54	18.1%	
Annual Premium	**1074**	$1,473,522	$1,246,113	$227,409		$1,343,752	$1,116,343	$227,409		
Cigna DHMO										
EE Only	91	$13.08	$13.08	$0.00	0.0%	$12.30	$12.30	$0.00	0.0%	$0.00
EE + Spouse	38	$25.98	$25.98	$0.00	0.0%	$24.42	$24.42	$0.00	0.0%	$0.00
EE + Child(ren)	50	$33.38	$33.38	$0.00	0.0%	$31.38	$31.38	$0.00	0.0%	$0.00
EE + Family	93	$50.49	$50.49	$0.00	0.0%	$47.46	$47.46	$0.00	0.0%	$0.00
Annual Premium	**272**	$102,505	$102,505	$0		$96,360	$96,360	$0		
VSP Vision										
EE Only	506	$7.15	$7.15	$0.00	0.0%	$7.15	$7.15	$0.00	0.0%	$0.00
EE + Spouse	216	$11.11	$10.11	$1.00	9.0%	$11.11	$10.11	$1.00	9.0%	$0.00
EE + Child(ren)	198	$11.57	$10.07	$1.50	13.0%	$11.57	$10.07	$1.50	13.0%	$0.00
EE + Family	420	$18.52	$16.52	$2.00	10.8%	$18.52	$16.52	$2.00	10.8%	$0.00
Annual Premium	**1340**	$193,043	$176,807	$16,236		$193,043	$176,807	$16,236		
ANCILLARY TOTAL		**$1,769,070**	**$1,525,425**	**$243,645**	**13.8%**	**$1,633,156**	**$1,389,511**	**$243,645**	**14.9%**	
DOLLAR CHANGE FROM CURRENT						**-$135,915**	**-$135,915**	**$0**		
PERCENT CHANGE FROM CURRENT						**-7.7%**	**-8.9%**	**0.0%**		
GRAND TOTAL		**$20,666,469**	**$18,674,745**	**$1,991,725**	**9.6%**	**$19,217,019**	**$17,255,423**	**$1,961,595**	**10.2%**	
DOLLAR CHANGE FROM CURRENT						**-$1,449,451**	**-$1,419,321**	**-$30,130**		
PERCENT CHANGE FROM CURRENT						**-7.0%**	**-7.6%**	**-1.5%**		

Recommendations:

- **Cigna Dental Plans**: Keep the current employee contributions level for 2021
- **VSP Vision Plan:** Keep the current employee contributions level for 2021

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8400

Recommended Action

Recommend approving the redirection of up to $2.0 million of IGT 9 funds originally allocated for the Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) Pilot towards contracting with a 24/7 virtual urgent care vendor for services that will include implementation and rapid deployment support for CalOptima Community Network (CCN) members during and after the COVID-19 pandemic

Background

On April 2, 2020, the Board of Directors (the Board) approved the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives within four focus areas: member access and engagement, quality performance, data exchange and support and other priority areas (refer to Attachment 1). Among these focus areas, the Board approved allocating $2.0 million for Expanded Office Hours to improve member access and engagement.

On May 7, 2020, CalOptima staff presented the Virtual Care Strategy and Roadmap (refer to Attachment 2) to provide additional access to quality care for our members and providers during and after the pandemic. One of the strategies introduced to the Board was to contract with a vendor offering virtual urgent care visits, including after-hour access for all CalOptima members regardless of network assignment for acute non-emergency medical conditions and behavioral health conditions. However, this strategy was postponed due to lack of available funding and deferred until CalOptima staff is able to identify appropriate funding.

As the COVID-19 pandemic continues to spread and disrupt the lives of many CalOptima members, CalOptima staff re-evaluated the structure of the Expanded Office Hours program and concluded that CalOptima is faced with new access challenges due to the COVID-19 pandemic that should be addressed. The Expanded Office Hours program was originally designed to provide additional office hours access to members in highly demanded and impacted areas. However, with the ongoing pandemic, members are less willing to come into the office for routine and preventive care services due to fear of COVID-19 and many provider offices are experiencing decreased office visits, and hence are less willing to expand their available office hours.

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Discussion

The Expanded Office Hours pilot was proposed as a two-year program to incentivize primary care providers and/or clinics to expand after-hour primary care services for CalOptima members in highly demanded and highly impacted areas. Unfortunately, this program was developed before the COVID-19 pandemic, and CalOptima staff now recommends shifting our efforts to support the urgent needs of our members through the use of virtual care.

CalOptima staff proposes redirecting the $2 million IGT-9 funds originally allocated for the Expanded Office Hours pilot to release a Request for Proposal (RFP) and selecting a vendor that meets our CCN members' medical needs and CalOptima's business requirements during the COVID-19 pandemic. Staff recommends starting this program with CCN members first and will consider extending it to other networks in the future. Staff will return to the Board to seek authority for approval to contract with the recommended vendor selected through the RFP process for services that will include a virtual care platform and virtual provider network, along with virtual care expertise to ensure a successful implementation of the 24/7 virtual urgent care initiative, including member and provider engagement and adoption.

With this proposed virtual care strategy, CalOptima staff believe that virtual urgent care after hours can improve member access to needed care on demand, decrease wait times, and reduce avoidable emergency department visits.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for as part of the Medi-Cal capitation revenue CalOptima receives from the Department of Health Care Services (DHCS) in exchange for making covered, medically-necessary care available to assigned Medi-Cal beneficiaries. Any expenditures of IGT-9 funds not meeting these requirements are categorized by the DHCS as part of CalOptima's administrative expenses. The recommendation to redirect Board-allocated IGT 9 funds to virtual urgent care services is consistent with the purpose of the IGT 9 funds to cover medically necessary Medi-Cal services or qualifying quality initiatives.

Fiscal Impact

The recommended action to redirect $2.0 million in IGT 9 funds from the Expanded Office Hours Pilot to support 24/7 virtual urgent care services for CCN members during the pandemic has no net impact to CalOptima's fiscal position. IGT 9 revenue from DHCS in Fiscal Year 2019-20 was sufficient to cover the allocated expenditures and initiatives. This expenditure of IGT funds is for a restricted, one-time purpose for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

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Rationale for Recommendation

The recommended action is consistent with the original aim for IGT 9 to improve Member Access and Engagement and will enable CalOptima to provide increased access to quality care for CCN members during and after the pandemic.

Concurrence

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

Attachments

1. Board Action dated April 2, 2020, Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds
2. Board Action dated May 7, 2020, Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging Services Vendor

/s/ Richard Sanchez — *09/23/2020*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds

Contact

David Ramirez, Chief Medical Officer (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400
Candice Gomez, Executive Director Program Implementation (714) 246-8400

Recommended Actions

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

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2020-2011 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS.

The IGT funds received under IGT 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds are incorporated into the contract between the California Department of Health Care Services (DHCS) and CalOptima for the current fiscal year. Funds must be used for CalOptima covered Medi-Cal services per DHCS requirements. Upon Board approval, funds may be allocated and used over multiple years. IGT 8 funds have been allocated to the Homeless Health Initiative. In July 2018, CalOptima received notice from DHCS regarding the fiscal year 2018-19 Voluntary Rate Range IGT 9. While supporting documents were submitted to DHCS in August 2018, IGT 9 funds have not yet been received or allocated. Submission of documentation to participate in IGT 9 was ratified at the September 9, 2018

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Board of Directors meeting. CalOptima is expected to receive funding from DHCS in calendar year 2020. CalOptima's estimated share is expected to be approximately $45 million. Following consideration by the Quality Assurance Committee and Finance and Audit Committee at their respective February 2020 meetings and the committees' recommendations for approval by the full Board, this item was presented for approval at the March CalOptima Board meeting. At that meeting, staff was directed to conduct further study and provide additional details related to the Whole Child Model pilot program (WCM) and the program's financial performance. Details on the WCM program are provided in a separate WCM-specific Information Item.

Discussion

While IGT 1-7 funds were available to provide enhanced services to existing CalOptima Medi-Cal beneficiaries, beginning with IGT 8, the requirement is that IGT funds are to be used for Medi-Cal program covered services and operations. IGT 8 (and subsequent IGT) funds are subject to all applicable requirements set forth in the CalOptima Medi-Cal contract with DHCS and are considered part of the capitation payments CalOptima receives from DHCS and are accounted for as either medical or administrative expenses, and factor into CalOptima's Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR). As indicated, per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

While IGT 9 funds have not yet been received, CalOptima staff has begun planning to support use of the funds. CalOptima staff has considered the DHCS requirements for use of IGT 9 funds and Board approved strategic priorities and objectives in identifying the following focus areas:

- Member access and engagement
- Quality performance
- Data exchange and support
- Other priority areas

CalOptima staff has and will continue to share information about the proposed focus areas with various stakeholders.

CalOptima staff anticipates receiving approximately $45 million in IGT 9 funding. Staff has identified initiatives within four focus areas targeting $40.5 million of the anticipated $45 million. Staff proposes approval of the five initiatives and allocation of funds in the focus areas as noted below and as further described in the attached IGT Funding Proposals:

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	$2.0 million

4. IGT Program Administration	Other priority areas	Five–years	$2.0 million
5. Whole Child Model (WCM) Program	Other priority areas	One–year	Up to $31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	$4.5 million

CalOptima staff will return to the Board with recommendations related the remaining estimated $4.5 million towards member access and engagement, as well as regarding new and/or modified policies and procedures, and contracts, if necessary.

Fiscal Impact

The recommended action has no net fiscal impact to CalOptima's operating budget over the proposed project terms. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures and initiatives recommended in this COBAR.

Rationale for Recommendation

CalOptima staff is recommending the use of IGT funds in a manner consistent with state parameters for IGT funds, identified focus areas.

Concurrence

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

Attachments

1. Power Point Presentation: Intergovernmental Transfer (IGT) 9 Update
2. CalOptima Board Action dated September 6, 2018, Consider and Authorize Activities to Secure Medi-Cal Funds through IGT 9
3. CalOptima Board Action dated June 6, 2019, Approve Post-Acute Infection Prevention Quality Initiative and Authorize Quality Incentive Payments
4. IGT Funding Proposals

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

CalOptima
A Public Agency
Better. Together.

Intergovernmental Transfer (IGT) 9 Update

Board of Directors Meeting
April 2, 2020

David Ramirez, M.D., Chief Medical Officer
Nancy Huang, Chief Financial Officer
Candice Gomez, Executive Director, Program Implementation

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IGT Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGT 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
    - Funds are outside of operating income and expenses
  - IGT 8–10: Funds must be used for Medi-Cal covered services for the Medi-Cal population
    - Funds are part of operating income and expenses

IGT Funding Process

High-Level Overview
1. CalOptima receives DHCS notice announcing IGT opportunity
2. CalOptima secures funding partnership commitments (e.g., UCI, Children and Families Commission, et al.)
3. CalOptima submits Letter of Interest to DHCS listing funding partners and their respective contribution amounts
4. Funding partners wire their contributions and an additional 20% fee to DHCS
5. CMS provides matching funds to DHCS
6. DHCS sends total amount to CalOptima
7. From the total amount, CalOptima returns each funding partner's original contribution
8. From the total amount, CalOptima also reimburses each funding partner's 20% fee and where applicable, retained amount for MCO tax (IGT 1–6 only)
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees

CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	$12.43 million	September 2012
IGT 2	$8.70 million	June 2013
IGT 3	$4.88 million	September 2014
IGT 4	$6.97 million	October 2015 (Classic)/ March 2016 (MCE)
IGT 5	$14.42 million	December 2016
IGT 6	$15.24 million	September 2017
IGT 7	$15.91 million	May 2018
IGT 8	$42.76 million	April 2019
IGT 9*	TBD	TBD (Spring 2020)
IGT 10*	TBD	TBD
Total Received	**$121.31 million**	

** Pending DHCS guidance*

IGT 9 Status

- CalOptima's estimated share is approximately $45 million
  - Expect receipt of funding in calendar year 2020
  - Funds used for Medi-Cal programs, services and operations
  - Funds are part of operating income and expenses
    - Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR) apply
    - Managed through the fiscal year budget

- Stakeholder vetting on the following focus areas
  - Member access and engagement
  - Quality performance
  - Data exchange and support
  - Other priority areas

Proposed Allocation and Initiatives

- Staff has identified initiatives targeted $40.5 million of the anticipated $45 million

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	$2.0 million
4. IGT Program Administration	Other priority areas	Five–years	$2.0 million
5. W hole Child Model Program	Other priority areas	One–year	Up to $31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	$4.5 million

1. Member Access and Engagement: Expanded Office Hours

- Description
  - Offer additional incentives to providers and/or clinics
    - Expand office hours in the evening and weekends
    - Expand primary care services to ensure timely access
- Guidelines
  - Primary care providers in community clinics serving members in high-demand/impacted areas are eligible
  - Per-visit access incentive awarded to providers and/or clinics for members seen during expanded hours
- Key Components
  - Two-year initiative
  - Budget request of $2.0 million ($500,000 in FY 2019–20)

2. Quality Performance: Post-Acute Infection Prevention Initiative (PIPQI)

- Description
  - Expand CalOptima's PIPQI to suppress multidrug-resistant organisms in contracted skilled nursing facilities (SNFs) and decrease inpatient admissions for infection
- Guidelines
  - Phase 1: Training for 41 CalOptima-contracted SNFs not currently participating in initiative
  - Phase 2: Compliance, quality measures and performance incentives for all participating facilities
  - Two FTE to support adoption, training and monitoring
- Key Components
  - Three-year initiative
  - Budget request of $3.4 million ($1 million in FY 2019–20)

3. Data Exchange: Hospital Data Exchange Incentive

- Description
  - Support data sharing among contracted and participating hospitals via use of CalOptima selected vendors
    - Other organizations within the delivery system may also be added
  - Enhance monitoring of hospital activities for CalOptima's members, aiming to improve care management and lower costs
- Guidelines
  - Participating organizations will:
    - Work with CalOptima and vendor to facilitate sharing of ADT (Admit, Discharge, Transfer) and Electronic Health Record data
    - Be eligible for an incentive once each file exchange is in place
- Key Components
  - One-year initiative
  - Budget request of $2.0 million (CY 2020)

4. Other Priorities: IGT Program Administration

- Definition
  - Administrative support for prior, current and future IGTs
    - Continue support for two existing staff positions to manage IGT transaction process, project and expenditure oversight
    - Fund Grant Management System license, public activities and other administrative costs
- Guidelines
  - Will be consistent with CalOptima policies and procedures
  - Will provide oversight of the entire IGT process and ensure funding investments are aligned with CalOptima strategic priorities and member needs
- Key Components
  - Five years of support
  - Budget request of $2.0 million

5. Other Priorities: Whole-Child Model (WCM) Program

- Definition
  - CalOptima launched WCM on July 1, 2019
  - Based on the initial analysis, CalOptima is projecting an overall loss of up to $31.1 million in FY 2019–20
- Challenges
  - Insufficient revenue from DHCS to cover WCM services
  - Complex operations and financial reconciliation
- Key Components
  - One year
  - Budget request of up to $31.1 million to fund the deficit from WCM program in FY 2019–20

Next Steps

- Return to the Board as needed regarding
  - New or modified policy and procedures
  - Contracts
  - Additional initiatives

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 September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Ratify and authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9), and;
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 9 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in seven Rate Range IGT transactions. Funds from IGTs 1 – 7 have been received and IGT 8 funds are expected in the first quarter of 2019. IGT 1 – 7 funds were retrospective payments for prior rate range years and have been used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. These funds have been best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

The IGT funds that have been received to date have supported special projects that address unmet needs for CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing unmet needs.

Discussion

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), IGT funds must now be used in the current rate year for CalOptima covered

services per DHCS instructions. CalOptima may determine how to spend the IGT funds (net proceeds) as long as they are for CalOptima covered services for Medi-Cal beneficiaries.

On July 31, 2018, CalOptima received notification from DHCS regarding the State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Intergovernmental Transfer Program (IGT 9). CalOptima's proposal, along with the funding entities' supporting documents were due to DHCS on August 31, 2018.

The five eligible funding entities from the previous IGT transactions were contacted regarding their interest in participation. All five funding entities have submitted letters of interest regarding participation in the IGT program this year. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to ratify the submission of the proposal letter to DHCS for participation in the 2018-19 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with the five proposed funding entities or their designated providers for the purpose of securing available IGT funds. Consistent with the eight prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to your Board with more information regarding the IGT 9 transaction and an expenditure plan for CalOptima's share of the net proceeds at a later date. .

Fiscal Impact
The recommended action to ratify and authorize activities to secure Medi-Cal funds through IGT 9 will generate one-time IGT revenue that will be invested in Board-approved programs/initiatives. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. As such, there is no net fiscal impact on CalOptima's current or future operating budgets as IGT funds have been accounted for separately.

Rationale for Recommendation
Consistent with the previous eight IGT transactions, ratification of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2018-19 (IGT 9).

Concurrence
Gary Crockett, Chief Counsel

Attachment
Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader — *8/29/2018*
Authorized Signature — **Date**

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

July 31, 2018

Greg Hamblin
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Mr. Hamblin:

The 2018-19 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of July 1, 2018 through June 30, 2019 (SFY 2018-19).

DHCS shall not direct the MCP's expenditure of payments received under the 2018-19 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the 2018-2019 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR SFY 2018-19:

MCPs should refer to the estimated SFY 2018-19 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the 2018-19 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. If an MCP elect to participate in the 2018-19 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the 2018-19 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.

2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for SFY 2018-19. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the "supplemental attachment" described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** (using the format provided in Attachment A) from each governmental funding entity included in the MCP's proposal to DHCS. An individual authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest. Each letter of interest must specify:

  1. The governmental funding entity's name and Federal Tax Identification Number,
  2. The dollar amount or percentage of the total available rate range the governmental funding entity will contribute for each MCP and county/region, and
  3. The governmental funding entity's primary contact information (name, e-mail address, mailing address, phone number).

- The MCP must distribute to governmental funding entities and ensure submission to DHCS of the **SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday, August 31, 2018.

- The proposals and letters of interest are due to DHCS ***by 5pm on Friday, August 31, 2018***. Please send a PDF copy of the required documents by e-mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the SFY 2018-19 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their

uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the 2018-19 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader, Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Financial Management Section
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

ATTACHMENT A – LETTER OF INTEREST TEMPLATE

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of [Insert Participating Funding Entity Name], a governmental entity, federal I.D. Number [Insert Federal Tax I.D. Number], in working with [Managed Care Plan's Name] (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the period of July 1, 2018, to June 30, 2019. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

[Insert Participating Funding Entity Name] is willing to contribute up to $_____ for the SFY 2018-19 rating period as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,
Signature

Attachment B

SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment

Provider Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by Friday, August 31, 2018.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2016 through June 30, 2017.

	Charges	Costs	Payments from Health Plan*	Uncompensated Chares (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2016 through June 30, 2017.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

   If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. For any capitation payments to be funded by the IGT, please provide the following:

   (i) The name of the entity transferring funds:

   (ii) The operational nature of the entity (state, county, city, other):

   (iii) The source of the funds:
   (Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations.)

   (iv) Does the transferring entity have general taxing authority? *(Yes / No)*

   (v) Does the transferring entity receive appropriations from a state, county, city, or other local government jurisdiction? *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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Orange County Organized Health System dba Cal Optima - Orange (HCP 506)
IGT - 2018/19 (July 2018 - June 2019)

	Total	50% FMAP (Non-MCHIP and OE)	88% FMAP (MCHIP)	Optional Expansion (93.5%)
Total Funds Available	$ 138,114,451	$ 68,412,249	$ 7,133,302	$ 62,568,900
Federal Match	$ 98,985,353	$ 34,206,125	$ 6,277,306	$ 58,501,922
Governmental Funding Entity's Portion	$ 39,129,098	$ 34,206,124	$ 855,996	$ 4,066,978
	28.3%	50.0%	12.0%	6.5%

Rate Categories[1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Dept. Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,474,781	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 12,571,887
Child - MCHIP	1,273,587	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 6,469,822
Adult - non MCHIP	1,082,406	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 18,898,809
Adult - MCHIP	38,000	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 663,480
SPD	466,754	$ 755.18	$ 798.48	$ 43.30	$ -	$ 43.30	$ 20,210,448
SPD/Full-Dual	22,704	$ 219.25	$ 229.52	$ 10.27	$ -	$ 10.27	$ 233,170
BCCTP	7,156	$ 1,225.69	$ 1,296.82	$ 71.13	$ -	$ 71.13	$ 509,006
LTC	14,686	$ 10,472.34	$ 10,858.28	$ 385.94	$ -	$ 385.94	$ 5,667,915
LTC/Full-Dual	0	$ 6,036.73	$ 6,235.58	$ 198.85	$ -	$ 198.85	$ -
OBRA	0	$ -	$ -	$ -	$ -	$ -	$ -
Whole Child Model	74,642	$ 1,824.65	$ 1,962.92	$ 138.27	$ -	$ 138.27	$ 10,321,014
Optional Expansion	2,853,119	$ 442.21	$ 471.45	$ 29.24	$ 7.31	$ 21.93	$ 62,568,900
	8,307,835	$ 309.49	$ 328.62	$ 19.14	$ 2.51	$ 16.62	$ 138,114,451

[1]The supplemental payments (Maternity, BHT and HEP C) are not included in the rate range calculation.
[2]Other Departmental Usages decreases available rate range funding.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

Background

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "…decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "…the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

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The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

Discussion

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

Phase I

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate

application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

Phase II

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.

Fiscal Impact

The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed $2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

Post-Acute Infection Prevention Quality Initiative

Regular Meeting of the Board of Directors

June 6, 2019

Dr. Emily Fonda, MD, MMM, CHCQM

Medical Director

Care Management, Long-Term Services and Supports and Senior Programs

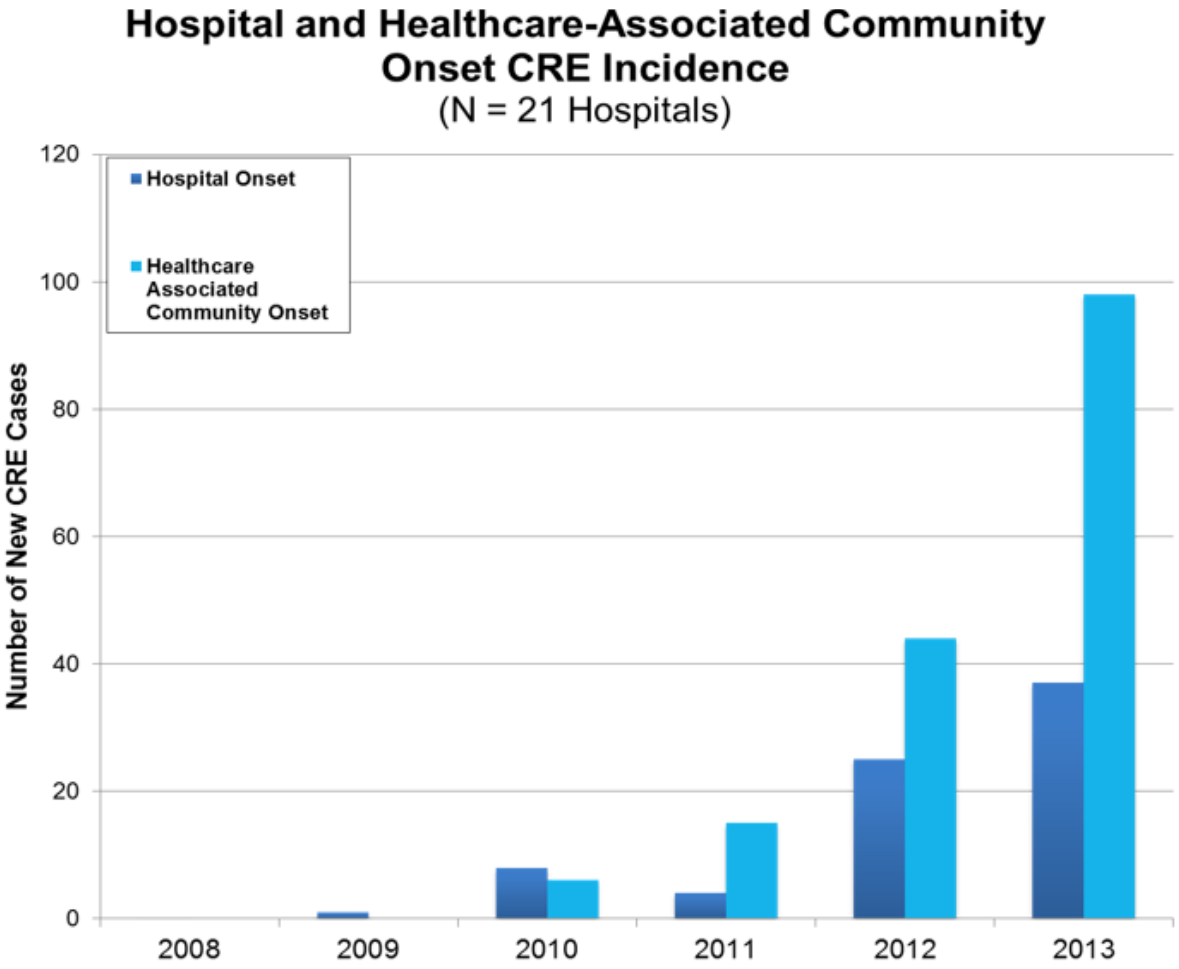
Background

- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
  - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
  - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
  - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 ➔ overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

Background

- Rise of Multi-Drug Resistant Organisms (MDROs)
  - Methicillin Resistant *Staphylococcus aureus* (MRSA)
  - Vancomycin Resistant Enterococcus (VRE)
  - Multi-Drug Resistant Pseudomonas
  - Multi-Drug Resistant Acinetobacter
  - Extended Spectrum Beta Lactamase Producers (ESBLs)
  - Carbapenem Resistant Enterobacteriaceae (CRE)
  - Hypervirulent KPC (NDM)
  - *Candida auris*
- **10–15%of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

CRE Trends in Orange County, CA



Gohil S. AJIC 2017; 45:1177-82

CDC Interest

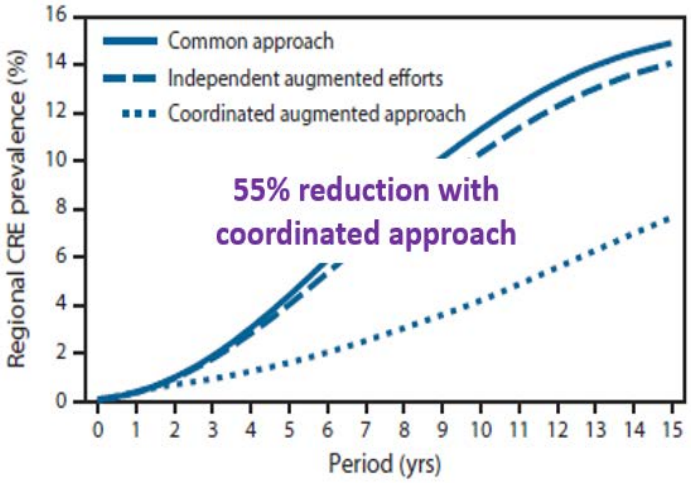
Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 64
August 4, 2015

Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

Rachel B. Slayton, PhD[1]; Damon Toth, PhD[2]; Bruce Y. Lee, MD[3]; Windy Tanner, PhD[2]; Sarah M. Bartsch, MPH[3]; Karim Khader, PhD[2]; Kim Wong, PhD[4]; Kevin Brown, PhD[2]; James A. McKinnell, MD[5]; William Ray[2]; Loren G. Miller, MD[6]; Michael Rubin, MD, PhD[2]; Diane S. Kim[7]; Fred Adler, PhD[8]; Chenghua Cao, MPH[7]; Lacey Avery, MA[1]; Nathan T.B. Stone, PhD[9]; Alexander Kallen, MD[1]; Matthew Samore, MD[2]; Susan S. Huang, MD[7]; Scott Fridkin, MD[1]; John A. Jernigan, MD[1]

FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California*

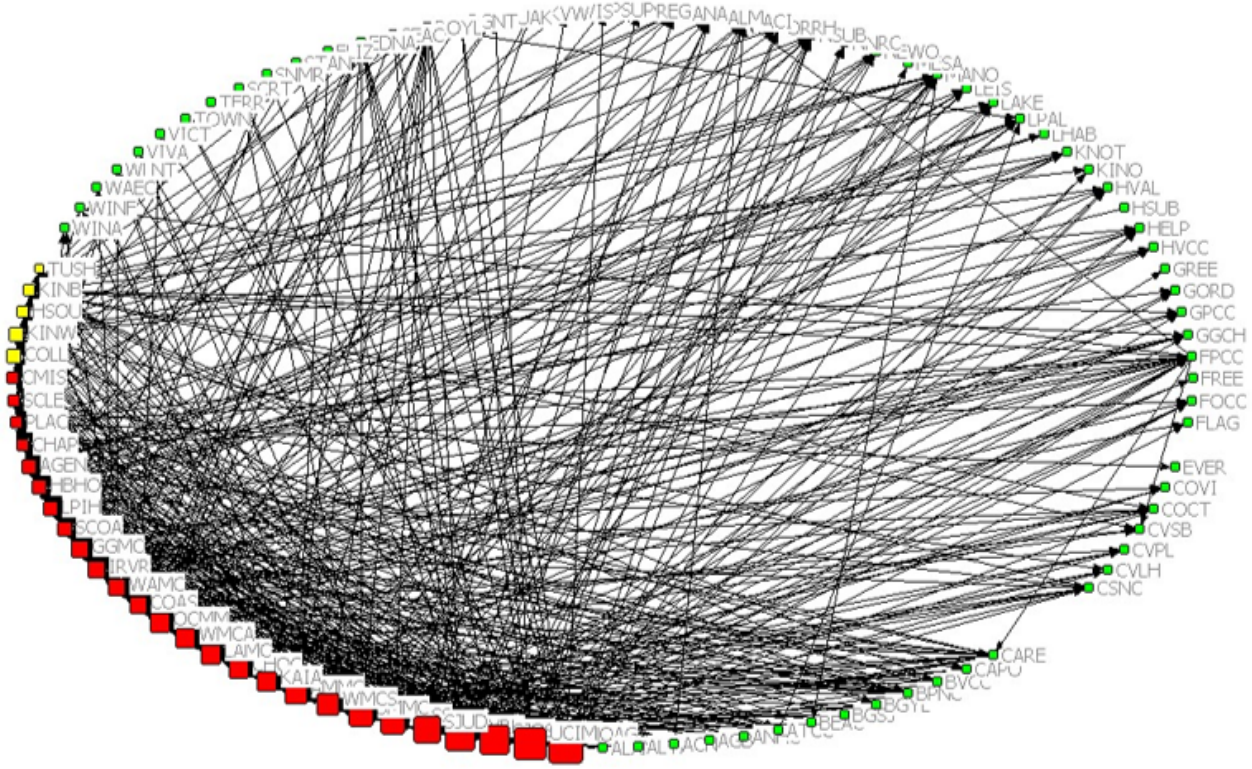


* Additional information available at http://www.cdc.gov/drugresistance/resources/publications.html.

Extent of the Problem

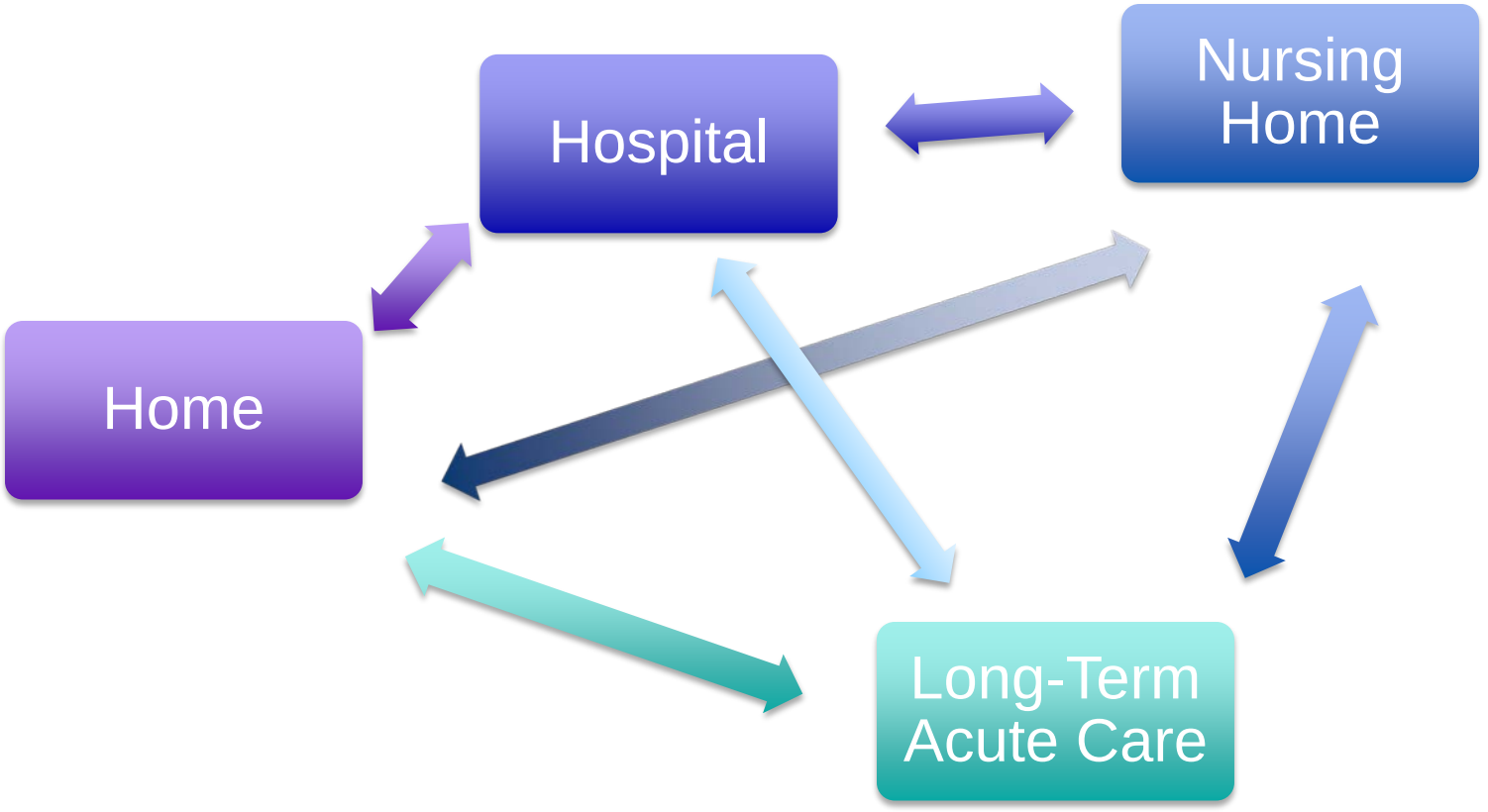
OC Hospitals and Nursing Homes

10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342

Extent of the Problem



Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	**900**	**64%**	**42%**	**16%**	**34%**	**2%**

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored ≥1 MDRO unknown to facility

Participating Health Care Facilities

16 Nursing Homes Contracted with CalOptima

- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

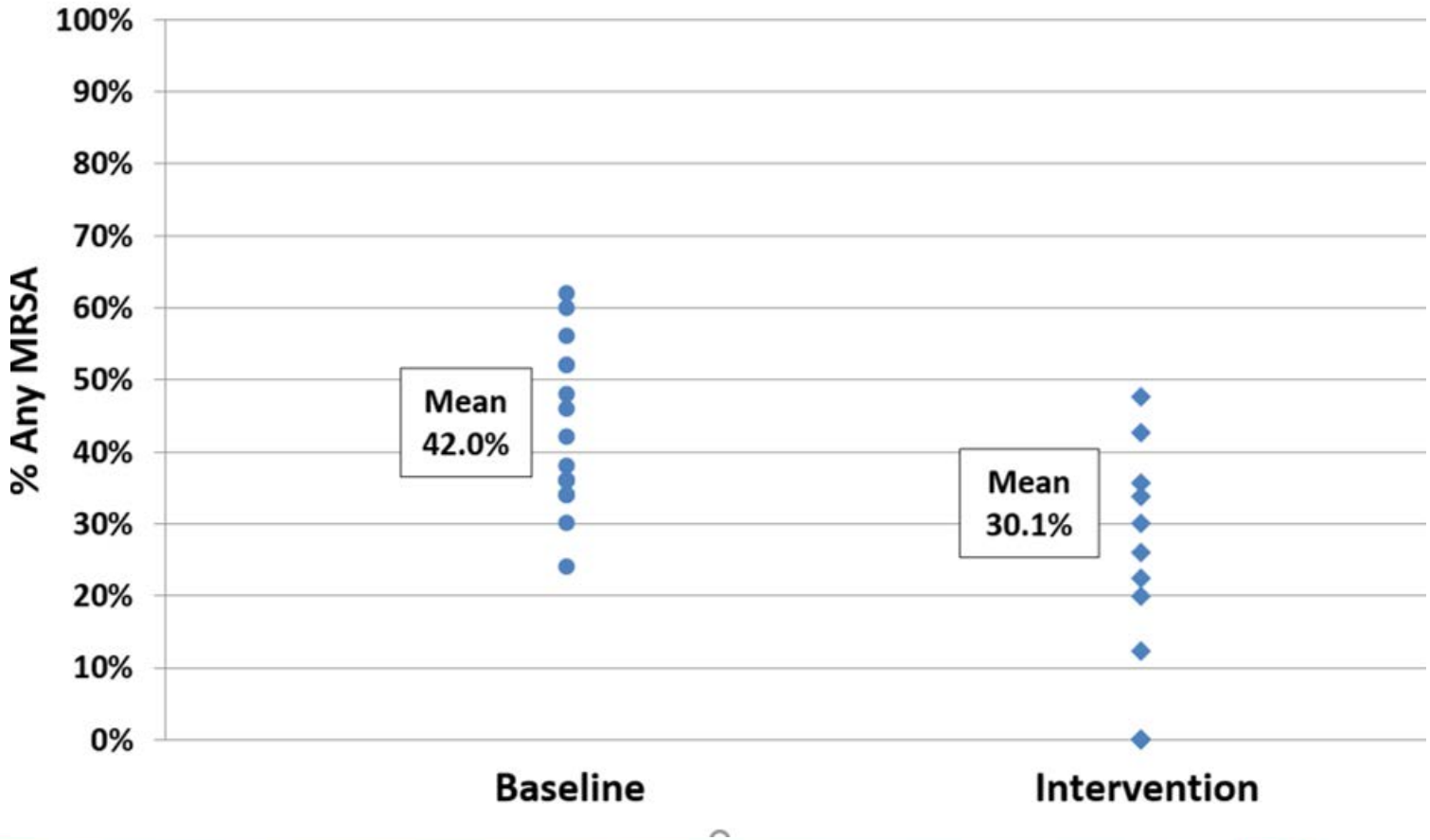
SHIELD OC Decolonization Protocol

- Nursing Homes: Decolonize All Patients
  - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
  - CHG on admit and for all routine bathing/showering
  - Nasal iodophor on admit and every other week
    - https://www.cdc.gov/hai/research/cdc-mdro-project.html
- Following initial testing and training
  - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
  - MRSA, VRE, ESBL, CRE and any MDRO
  - By body site
    - Nasal product reduces MRSA
    - CHG bathing reduces skin carriage

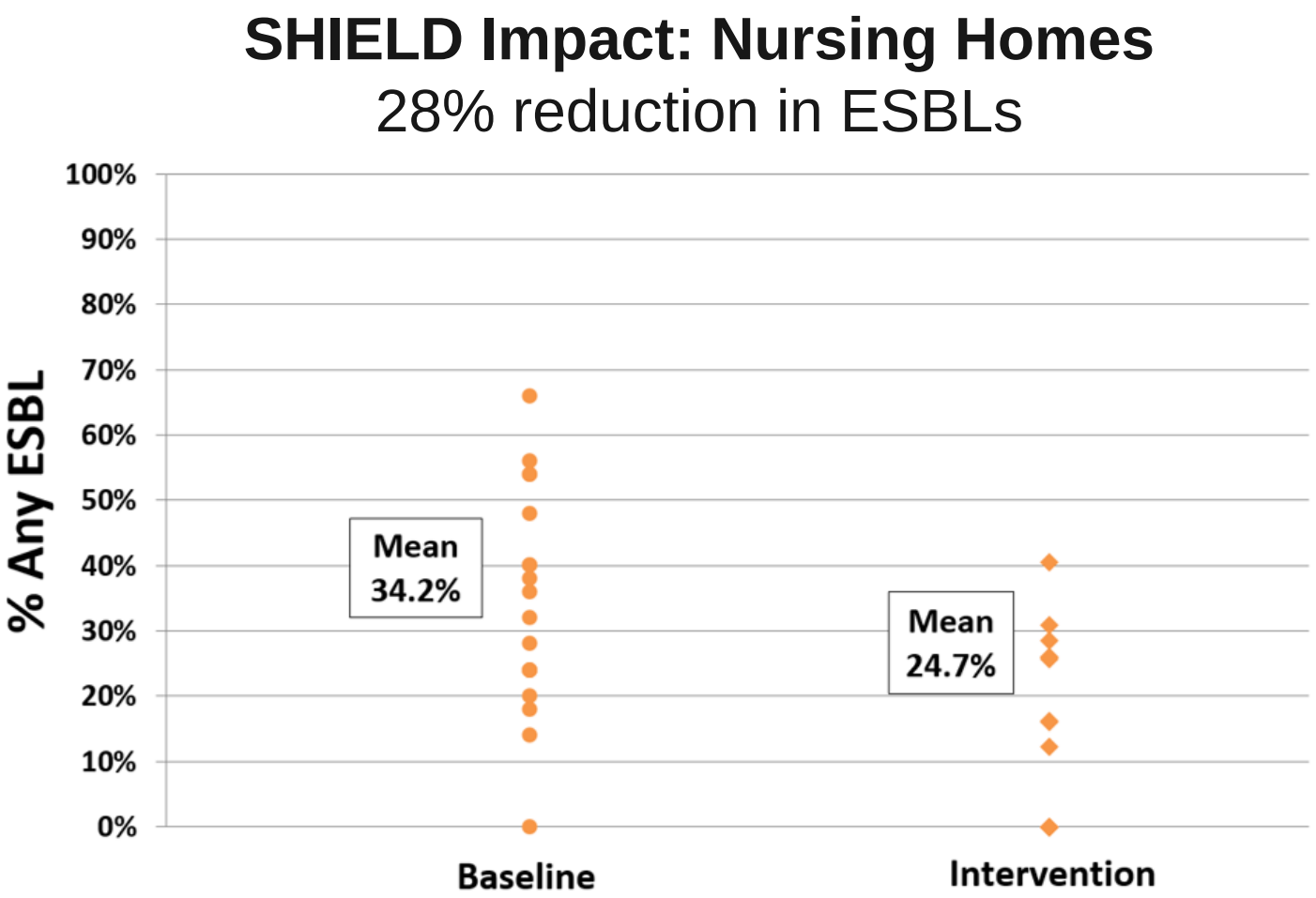
SHIELD Outcomes

SHIELD Impact: Nursing Homes

28% reduction in MRSA



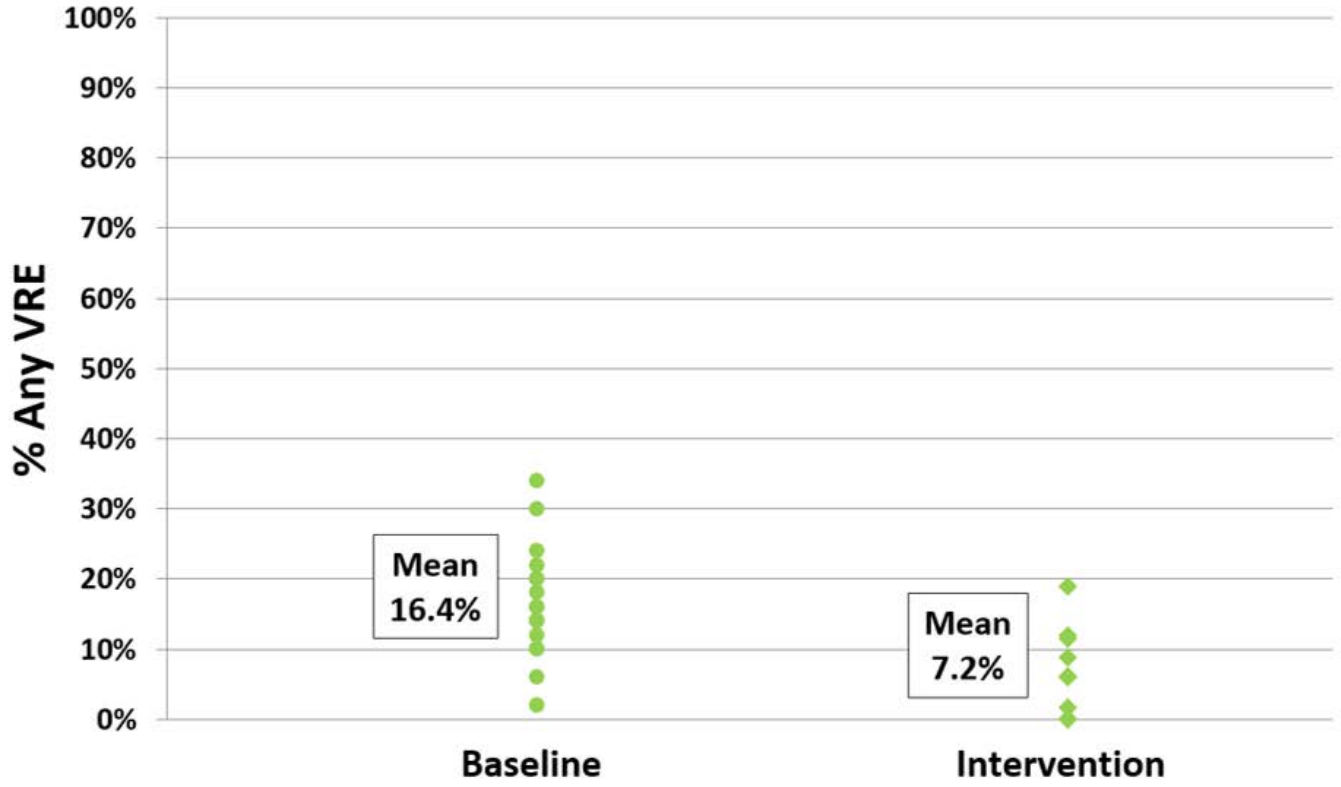
SHIELD Outcomes (cont)



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

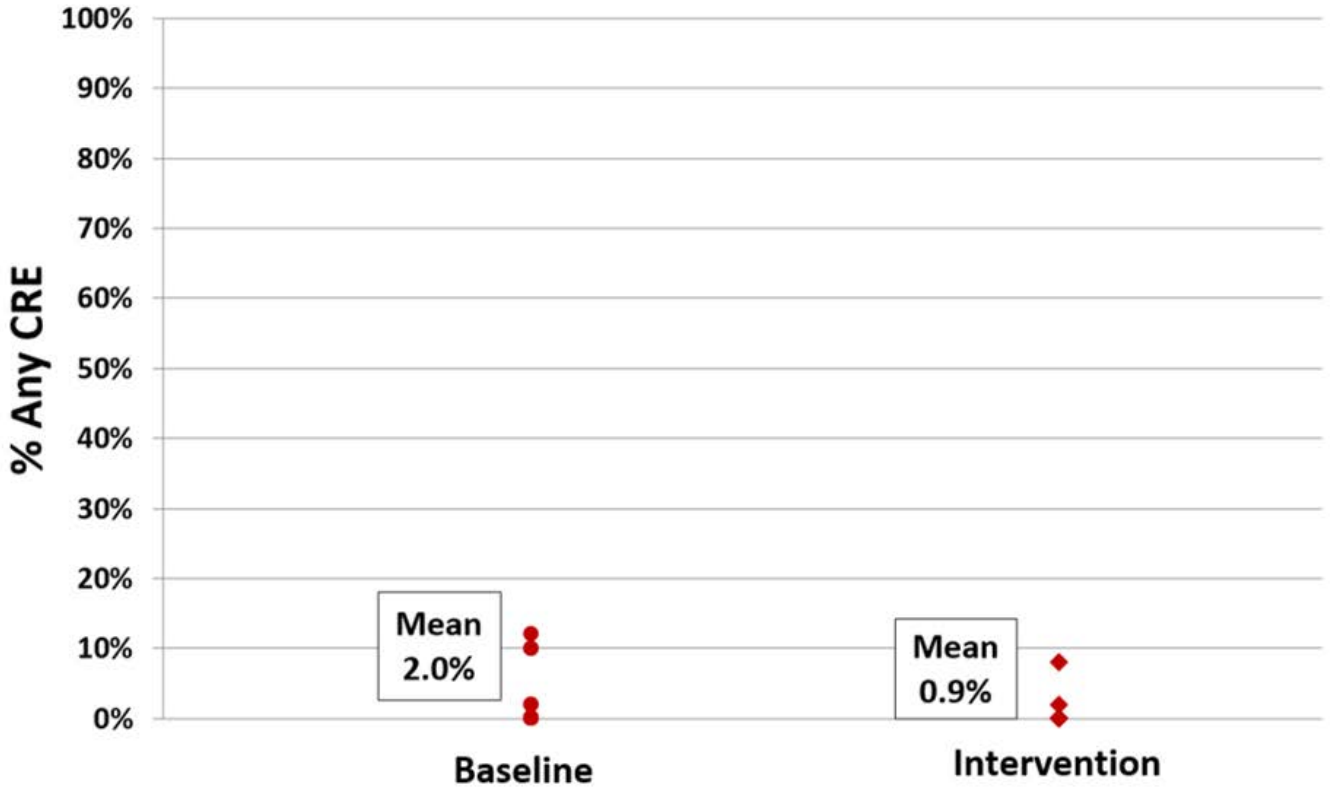
56% reduction in VRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

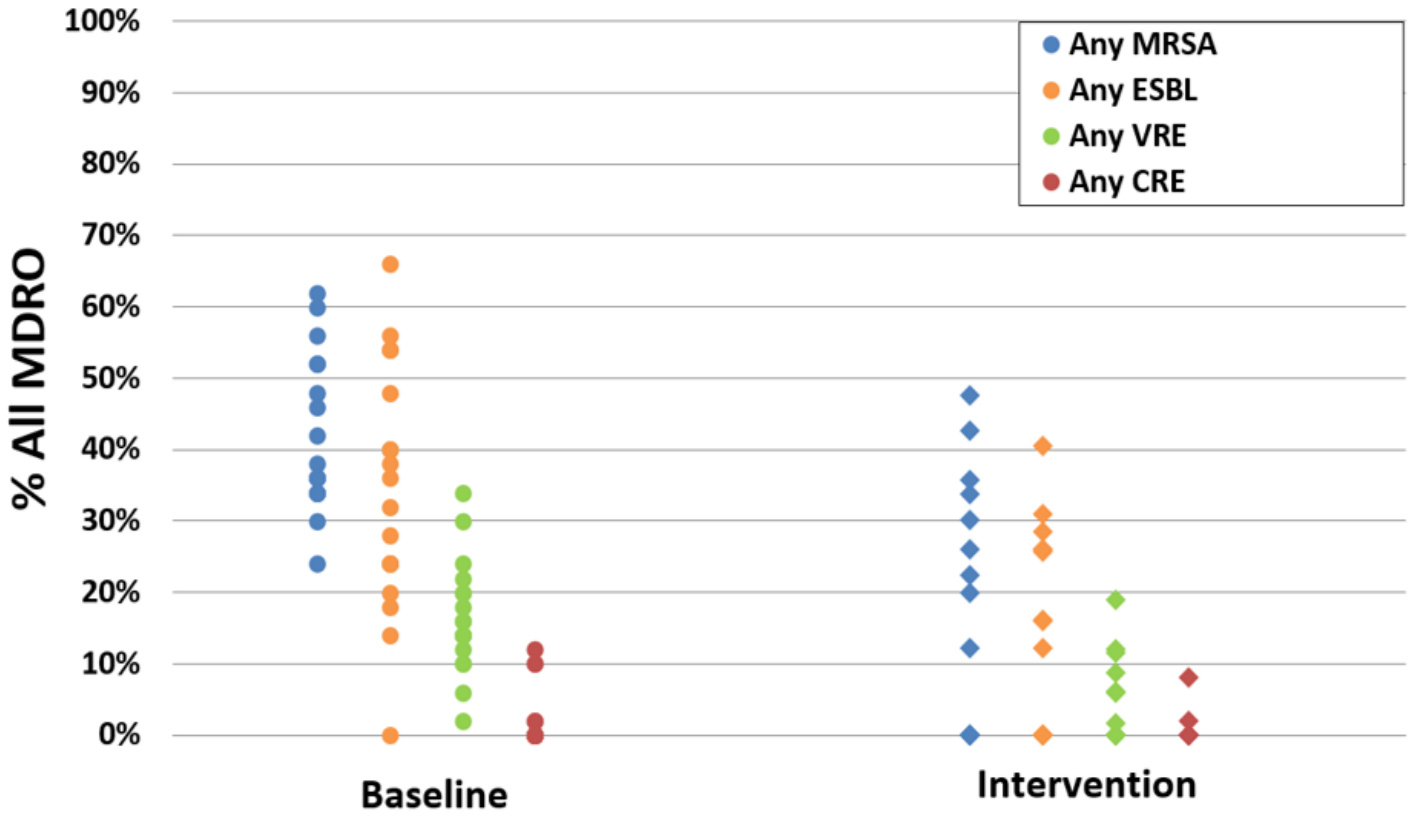
55% reduction in CRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

25% reduction in all MDROs



Quarterly Inpatient Trends

SHIELD OC Project: Quarterly Inpatient Trends
LTC Facility County: ORANGE
From: 2015-10 To: 2018-12
Category P - Primary Diagnosis

Select Year-Month Begin	Select Year-Month End	Select Category P Diagnosis Level	Select Risk Group *	Select LTC Facility County
2015-10	2018-12	Category P - Primary Diagnosis	Multiple values	ORANGE

		Before SHIELD OC						During SHIELD OC						
		2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	$682,769	$854,676	$1,159,922	$920,317	$1,691,337	$1,231,903	$997,810	$1,236,197	$634,628	$979,762	$1,113,238	$1,176,910	$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	$133,362	$311,661	$124,676	$189,669	$227,224	$209,419	$175,738	$164,181	$40,354	$84,565	$127,609	$41,123	$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC
Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

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CalOptima A Public Agency Better. Together.

Quarterly Inpatient Trends

- 16 contracted facilities utilizing the CHG program:
  - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = $1,196,011
  - Inpatient costs for the last 6 quarters following training and use of CHG protocol = $468,009
    - $728,002 lowered inpatient expenditure (61%) for infection in the participating facilities

- 51 contracted facilities not utilizing the CHG program:
  - Inpatient costs for the last 6 quarters =$6,165,589
  - Potential 61% lowered inpatient expenditure for infection = $3,761,009 if the CHG protocol had been expanded

SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
  - Plan for extended use of an existing trainer in OC for one year
  - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
  - Decreased infection-related hospitalizations
  - An opportunity for a significant advancement in population health management
  - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
  - Continuation of cost savings

CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
  - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
  - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
  - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
  - Include a trainer provided by the CDC for one year
  - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
  - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

Recommended Actions

- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

CalOptima's Mission

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


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs in
Orange County

SHIELD Orange County – *Together We Can Make a Difference!*

What is SHIELD Orange County?

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

Visit our CDC webpage here!
https://www.cdc.gov/hai/research/cdc-mdro-project.html

SHIELD OC Goals:

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

Who is participating?

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

What is the decolonization intervention?

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
  - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
  - Nasal decolonization with 10% povidone-iodine
  - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
  - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
  - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

With questions, please contact the SHIELD OC Coordinating Team

(949) 824-7806 or SHIELDOrangeCounty@gmail.com

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CalOptima Checklist

Nursing Home Name: _____

Month Audited (Month/year): _____/_____

Today's Date: _____/_____/_____

Completed by: _____

- ☐ Proof of product purchase
- ☐ Evidence the decolonization program handout is in admission packet
- ☐ Monitor and document compliance with bathing one day each week
- ☐ Monitor and document compliance with iodophor one day each week iodophor is used
- ☐ Conduct three peer-to-peer bathing skills assessments per month

Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	☐	_____ gallons	_____ gallons
10% Iodine Swabsticks	☐	_____ boxes	_____ boxes
		_____ swabs per box	

INTERNAL USE ONLY –APPROVAL:

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Facility Name: _____Unit: _____ Date: _____

STAFF Skills Assessment:
CHG Bed Bath Observation Checklist

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

☐ **Nursing Assistant (CNA)** ☐ **Nurse** ☐ **LVN** ☐ **Other: _____**

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

☐ **Y** ☐ **N** **Resident received CHG bathing handout**
☐ **Y** ☐ **N** **Resident told that no rinse bath provides protection from germs**
☐ **Y** ☐ **N** **Provided rationale to the resident for not using soap at any time while in unit**
☐ **Y** ☐ **N** **Massaged skin *firmly* with CHG cloth to ensure adequate cleansing**
☐ **Y** ☐ **N** **Cleaned face and neck well**
☐ **Y** ☐ **N** **Cleaned between fingers and toes**
☐ **Y** ☐ **N** **Cleaned between all folds**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned occlusive and semi-permeable dressings with CHG cloth**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned 6 inches of all tubes, central lines, and drains closest to body**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on surgical wounds (unless primary dressing or packed)**
☐ **Y** ☐ **N** **Allowed CHG to air-dry / does not wipe off CHG**
☐ **Y** ☐ **N** **Disposed of used cloths in trash /does not flush**

Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

_____

2. If more than 6 cloths was used, provide reason.

_____

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

_____

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

_____

5. Do you ever wipe off the CHG after bathing?

_____

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ORIGINAL ARTICLE

Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

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ABSTRACT

BACKGROUND

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

METHODS

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

RESULTS

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

CONCLUSIONS

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

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Methicillin-resistant *Staphylococcus aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.[1] It is the most common cause of skin, soft-tissue, and procedure-related infections.[2] Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.[1,3,4]

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.[5,6] Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).[7-10] Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

Methods

Trial Design and Intervention

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge (Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

Recruitment and Eligibility Criteria

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

Follow-up

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits ($25, $30, $35, and $50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

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talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.[11] A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)[12] or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine (≥8 μg per milliliter) on microbroth dilution.[13,14] All outcomes were assessed on the basis of the first event per participant.

DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the participant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and nonadherence (no doses used).

STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

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for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.[15] Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

RESULTS

PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ($P=0.32$); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ($P<0.001$); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ($P=0.41$); and death in 10.7% (114) and 9.3% (98), respectively ($P=0.26$). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approximately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a

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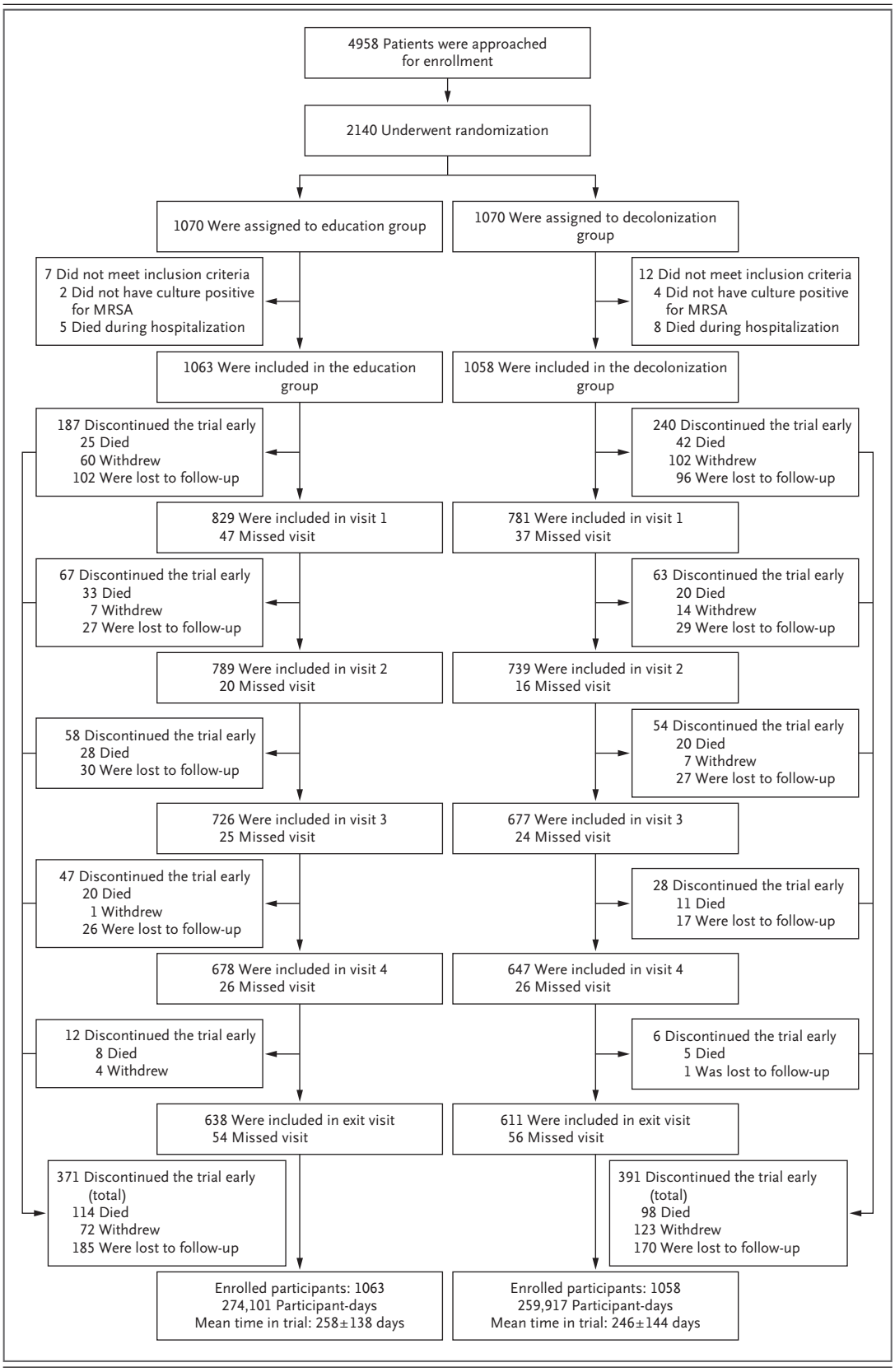

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Figure 1 (facing page). Randomization and Follow-up of the Participants.

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean (±SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

EFFECT OF ADHERENCE

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-

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Table 1. Characteristics of the Participants at Recruitment Hospitalization.*

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares‖	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

* Plus–minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.
† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.
‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.
§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.
¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.
‖ By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).
** Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.
†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.
‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

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Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.*

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
All Participants								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading in hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
Adherent Participants in Decolonization Group‡								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.
† This was the primary outcome.
‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

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Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.*

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
Per-protocol analysis				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96)†	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI)‡	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
As-treated analysis§				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI)¶				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

† A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

‡ Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

§ The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

¶ As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infection was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

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categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group, P=0.97). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group, P=0.82) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8 μg or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8 μg per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care–associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.[16] MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.[1,17-19] In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.[16]

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),[6-10,19-22] a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.[23-26] In contrast, twice-monthly decolonization provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

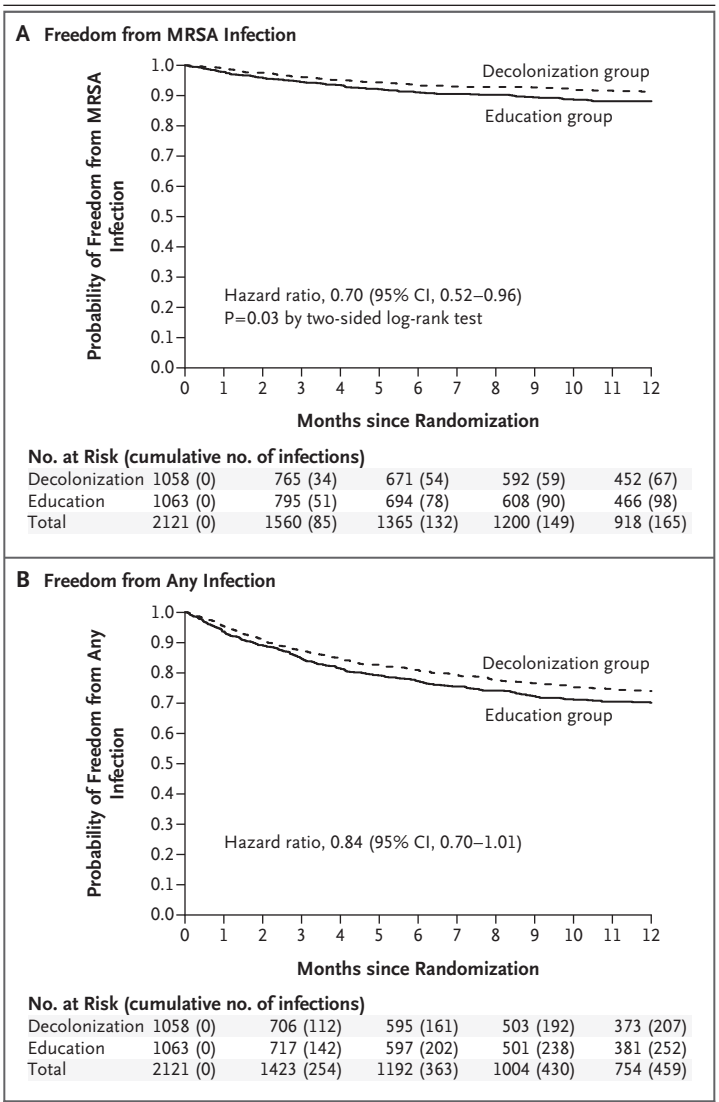

Figure 2. Kaplan–Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

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ing and mupirocin application.[8,9,22] This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.[8,9,22]

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.[27-30]

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8 μg per milliliter, although 4% chlorhexidine applies 40,000 μg per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.[31-33] It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive

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cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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APPENDIX

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PUBLIC HEALTH

Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

April 2, 20195:00 AM ET

ANNA GORMAN



A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics. *Heidi de Marco/KHN*

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC's office on health care-acquired infection research.

"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15 percent of hospital patients and 65 percent of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, says Dr. Susan Huang, who specializes in infectious diseases at the University of California, Irvine.
"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or CRE, often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."
Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it.



The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.
Heidi de Marco/KHN

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused rare but severe allergic reactions.
In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.
In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency
"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.



Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.
Heidi de Marco/KHN

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, published in February in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.

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In a nearby room, senior project coordinator Raveena Singh from UCI talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. "If you have some kind of open wound or cut, it helps protect you from getting an infection," Singh said. "And we are not just protecting you, one person. We protect everybody in the nursing home."

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Coventry Court administrator Shaun Dahl says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says.
Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says. "This offers an opportunity to intervene and bend the curve in the right direction."

Kaiser Health News is a nonprofit news service and editorially independent program of the Kaiser Family Foundation. KHN is not affiliated with Kaiser Permanente.

USA TODAY

How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | **Updated 1:47 p.m. ET April 12, 201**

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

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USA TODAY



Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. *(Photo: Heidi de Marco, Kaiser Health News)*

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Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

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Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.

DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

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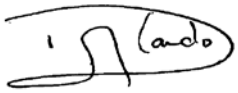
We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,



Denise Cardo, MD
Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

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Attachment 4: IGT Funding Proposals

Proposal 1: Expanded Office Hours

Initiative Description: The Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) is a two-year program to incentivize primary care providers and/or clinics for providing after-hour primary care services to CalOptima members in highly demanded and highly impacted areas. The Expanded Office Hours aims to improve member experience, timely access to needed care, and achieve positive population health outcomes.

Target Population(s): Primary care providers serving CalOptima's Medi-Cal members in highly demanded/impacted areas

Plan of Action/Key Milestones:
High level actions of how CalOptima will invest financial and staff resources to support the Expanded Office Hours initiative, such as:

1. Provider Data Gathering and Internal System Configuration
    - Identify primary care providers in community clinics who serve members in highly demanded and impacted areas
    - Configure the internal system (using codes 99050 and 99051) so claims can be adjudicated, and providers can receive expanded office hour incentives.
        - CPT code descriptions:
            - 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
            - 99051: Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
2. Provider Outreach
    - Collaborate with Provider Relations and Health Network Relations to promote the opportunity and encourage providers to provide these services.
    - $125 per member per visit incentive
3. Announce the Expanded Office Hours initiative to impacted Members
    - Call Center and frontline staff training
4. Monitor utilization of the expanded office hour services
    - Monitor and report claims and encounter for identification and linkage to primary care providers providing expanded office hour services

5. Evaluation
    - Conduct evaluation after pilot to see if member access has improved and depending on the outcome, consider expanding the initiative.

Estimated Budget: Total $2 million (up to $500,000 for FY2019/20, remaining amounts from FY2019/20 and $750,000 for FY2020/21, $750,000 FY2021/22)

Project Timeframe: April 2020 – March 2022

IGT 9 Focus Area: Member access and engagement

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus

- Focus on Population Health
- Strengthen Provider Network and Access to Care
- Enhance Member Experience and Customer Service

Participating/Collaborating Partners/Vendors/Covered Entities: Participating providers

Proposal 2: Post-Acute Infection Prevention Initiative (PIPQI)

Initiative Description: Expand CalOptima's program to suppress Multi Drug Resistant Organisms (MDROs) in CalOptima's contracted nursing facilities and decrease inpatient admissions due to infection. The pilot program was approved by CalOptima's Board of Directors on June 6, 2019.

Benefits of the Initiative:

- Member-centric focus: avoid MDRO colonization and inpatient admissions
- Potential cost savings from decreased antibiotic utilization
- Decreased demand for antibiotic-related c. difficile isolation beds
- Decreased Healthcare Acquired Infection rates (HAI):
    - Potential improved Star ratings
    - Strengthens community and national partnerships:
        - UCI (Professor Susan Huang -Department of Infectious Diseases)
        - Matthew Zahn, MD, Orange County Health Care Agency-Division of Epidemiology, CDC
        - (John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention)
        - contracted nursing facilities
        - members/families
- Increased value and improved care delivery
- Enhanced operational excellence and efficiency

*Please note that there is currently an outbreak of a fungal infection called C. auris in Orange County LTACHs and NFs. It's a costly and virulent infection and the Public Health Department is involved. There are currently 160 cases in OC (need updated numbers). Chlorhexidine eradicates and protects against this fungus as well as Multi Drug Resistant Organisms (MDROs)

Target Member Population(s): CalOptima Members receiving services at contracted nursing facilities

Plan of Action/Key Milestones:

A. Teleconference requested by the CDC scheduled for April 2, 2020, as CalOptima is the only County in the U.S. that is an early adopter of CHG/Iodophor in NFs to lower MDRO colonization rates

B. Dedicate two Long Term Support Services Nurses to:

1) Provide training for newly participating facilities,
2) Provide ongoing support and compliance monitoring* at all participating facilities,
3) Develop additional informing, training and monitoring materials.

C. Promote the expansion of the Post-Acute of Infection Prevention Program and engage nursing facility administration and staff at the March 20, 202 LTSS Workshop.

*Monitoring includes monthly random testing (five patients per facility confirming presence of Chlorhexidine, invoices /delivery receipt for Chlorhexidine and Iodophor). Additional metrics: acute inpatient admission rates due to infection, Hospital Acquired Infection (HAI) rates.

Estimated Budget: Total budgeted amount $3.4 million over 3 fiscal years ($1 million for FY2019/20, $1.2 million for FY 2020/21 and $1.2 million for FY 2021/22)

Project Timeframe: Three years FY 2019/20– 2021/22

IGT 9 Focus Area: Quality performance and data exchange and support

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Expand CalOptima's Member-Centric Focus, Strengthen Community Partnerships, Increase Value and Improve Care Delivery, Enhance Operational Excellence and Efficiency.

Participating/Collaborating Partners/Vendors/Covered Entities: University of California Irvine Medical Center, Department of Infectious Disease, Dr. Susan Huang; Orange County Health Care Agency-Division of Epidemiology, Centers for Disease Control (CDC); John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention; CalOptima contracted nursing facilities.

Proposal 3: Hospital Data Sharing Initiative

Initiative Description: Establish incentives for implementation of a data sharing solution for Admit, Discharge, Transfer (ADT) and Electronic Health Record data to support alerting of hospital activities for CalOptima members for the purposes of improving care management. Participating entity will be eligible for incentive once each file exchange is in place. The overall goal is to improve costs, quality, care, and satisfaction.

Target Population(s): Contracted and participating Orange County hospitals serving CalOptima members and, potentially, other Community Based Organizations within the delivery system

Plan of Action/Key Milestones: Staff will obtain Board of Directors approval, contract with selected vendors, implement the solutions, establish an incentive plan and details, and work with the vendors and the hospitals to establish the means of sharing data.

Estimated Budget: $2 million to be exhausted by end of FY 2020-2021

Project Timeframe: Until end of FY 2020-2021

IGT 9 Focus Area: Data exchange and support

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus and Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: Hospitals providing the requested data

Proposal 4: Intergovernmental Transfer (IGT) Program Administration

Initiative Description: Administrative support activities related to prior, current and future IGTs opportunities, grants, internal initiatives. This will continue support for management of the IGT transaction process, project and expenditure oversight related to prior IGTs (outstanding grants and internal projects), as well as current IGTs in progress (i.e., IGTs 9 and 10) and oversight. Administration will be consistent with CalOptima standard policies, procedures and practices and will ensure funding investments are aligned with CalOptima's strategic priorities and member needs. Two staff positions, the Grant Management System license, public activities and other administrative costs are included.

Target Member Population(s): NA

Plan of Action/Key Milestones: NA

Estimated Budget: $2,000,000

Project Timeframe: Five–years

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Strengthen Community Partnerships, Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: NA

Proposal 5: Whole Child Model (WCM) Program

Initiative Description: To fund WCM program deficit in year one

Target Member Population(s): WCM eligible members (12,000 to 13,000)

Plan of Action/Key Milestones: N/A

Estimated Budget: Total $31.1 million for FY 2019-20

Project Timeframe: FY 2019-20 (July 1, 2019 to June 30, 2020)

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives:
To Support care delivery for WCM population in FY 2019-20

1) Insufficient revenue from DHCS
2) Complexity in operation and financial reconciliation

Participating/Collaborating Partners/Vendors/Covered Entities: N/A

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions

1. Approve Virtual Care Strategy and Roadmap;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to contract with vendor mPulse Mobile, a Mobile Health Interactive Text Messaging Services vendor; and
3. Approve the recommended allocation of intergovernmental transfer (IGT) 9 funds not to exceed $3.9 million for a three-year period to provide a text messaging solution for all CalOptima member communications.

Background

As the Coronavirus Disease (COVID-19) continues to spread and threatens lives of many vulnerable populations, the COVID-19 pandemic has created an urgency for CalOptima and other Managed Care Plans (MCPs) to expand their virtual care strategy immediately to ensure timely access to care for our members and support our providers' use of virtual care during the strict social distancing measures while providers experience shortages of Personal Protective Equipment (PPE).

As a result of the COVID-19 pandemic, the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements.

At its April 2, 2020 meeting, the CalOptima Board of Directors ratified various COVID-19 mitigation activities. In addition to the approval of Telehealth Policies and Procedures to include temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements in the event of a health-related national emergency, the Board authorized contracting with Virtual Care Consultant Sajid Ahmed of WISE Healthcare to help expedite the deployment of the CalOptima Virtual Care Strategy and Roadmap.

At the same meeting, the Board approved the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives within four focus areas: member access and engagement, quality performance, data exchange and support and other priority areas. At that time, the Board approved five initiatives totaling $40.5 million. Staff would return to the Board with recommendations for allocating the remaining $4.5 million towards member access and engagement.

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Discussion

In addition to the actions approved in response to COVID-19 to date, management recommends that the Board authorize the implementation of virtual care services for members and providers with long term implications beyond the COVID-19 pandemic.

Virtual Care Strategy and Roadmap

As the sophistication and simplification of mobile technology has evolved over time beyond telehealth, virtual care is a broad definition encompassing any modality of remote technologically driven patient health care delivery, device use, monitoring, and treatment. CalOptima staff cites to an adopted virtual care definition as "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care." [1]

CalOptima management plans to continue to use the term "telehealth" to include member materials approved by DHCS in order to be consistent with DHCS All Plan Letter (APL) 19-009: Telehealth Services Policy.

CalOptima's main Virtual Care Strategies include the following elements. Staff will return to the Board to seek authority for approval of implementation of the Virtual Care Strategies through specific vendors and initiatives in the future:

1. Support CalOptima's contracted providers' use of virtual visits during COVID-19 and beyond [all members]
    a. Technical assistance and operational support
    b. CalOptima virtual care team
    c. HIPAA compliant platform(s)
2. Contract with specialty providers with a virtual care focus for CCN members.
    a. Provider(s)/vendor(s) to treat chronic pain/opioid dependency, and provide medication assisted treatment, and eating disorder treatment
    b. Other specialties as available
3. Contract with a vendor offering virtual visits including after-hour access for all CalOptima members regardless of network assignment for acute non-emergency medical conditions and behavioral health conditions through its own provider network
    a. Integrate with CalOptima website and/or member portal
    b. Technical support for members
    c. Integrate with existing nurse advice line
    d. Develop member smartphone app
4. Contract with a vendor offering eConsults for CCN members and PCP's through CalOptima contracted specialists who wish to participate and/or its own provider network
    a. Technical assistance and operational support for CCN providers
    b. Integrate with CCN UM process
    c. Integrate with CCN provider portal
5. Member texting
    a. Via CalOptima member smartphone app

With these proposed Virtual Care Strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits:

- Improved member access and convenience;
- Reduced avoidable in person visits to specialists; and
- Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care:

- Improved member experience;
- Augmented network capacity and adequacy; and
- Improved clinical quality outcomes.

As recommended by staff, CalOptima's Virtual Care Strategy proposes a detailed logic model and a work plan which are included in the attachments (refer to Attachment 3 and Attachment 4).

Proposal to Implement Mobile Health Interactive Text Messaging Services

CalOptima currently uses traditional modes of member communication, including telephonic, print and mail. CalOptima staff seeks to strengthen communication outreach opportunities to our members through Mobile Health Interactive Text Messaging Services that will:

- Deliver useful health promotion and prevention messaging;
- Promote healthy behaviors among members;
- Facilitate behavior change;
- Provide support through impactful media;
- Promote wellness and preventive care including Healthcare Effectiveness Data and Information Set (HEDIS) measures;
- Improve clinical outcomes; and
- Encourage adherence to recommended care practices

CalOptima's RFP minimum requirements for the mobile texting vendor include the following:

- Provide Mobile Text Messaging services to enhance member engagement by supporting CalOptima in implementing a secure communication program designed to close gaps in care, improve quality scores, drive higher engagement and satisfaction for CalOptima's members.
- Deliver technology platform for managing outreach to CalOptima's members via text message. The interactive messages must operate as a reliable, secure, and high-speed messaging system of use in the health care environment.
- Ensue that content written at a sixth grade reading level or below so that the information is easy to understand.
- The Platform must be a Health Insurance Portability and Accountability Act (HIPAA) compliant platform with secure encryption texting capability to ensure the safe management of Protected Health Information (PHI) and other sensitive data.

Through a Request for Proposal (RFP) process conducted in 2019, CalOptima staff received eight (8) responses and with two finalist texting solution vendors, HealthCrowd and mPulse Mobile (mPulse). CalOptima's Mobile Texting RFP Selection workgroup is recommending that the Board authorize a

contract with mPulse based on it receiving the highest evaluation score (refer to Attachment 5) mPulse specializes in Conversational Artificial Intelligence (AI) solutions for the healthcare industry and promotes improved health outcomes by engaging individuals with tailored and meaningful dialogue. mPulse combines behavioral science, analytics and industry expertise to help healthcare organizations promote their members acquiring healthy behaviors. mPulse is HIPAA and Telephone Consumer Protection Act (TCPA)-compliant, and Health Information Trust (HITRUST) Alliance-certified.

CalOptima's Mobile Texting RFP Selection workgroup is recommending Board authorization for a contract of three years in an amount not to exceed $3,900,000. Based on the CalOptima membership, the estimated annual cost for the contract is approximately $1,000,000, with a separate expense of $80,256 for implementation and set-up. Staff recommends allocating IGT 9 funding not to exceed $3.9 million under the Board-approved focus area of Member Access and Engagement. In addition, staff recommends entering into further negotiations and pursing a contract with mPulse with the assistance of CalOptima's Procurement and Legal Departments.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from the DHCS in that, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's General and Administrative categories, which are included in administrative loss ratio (ALR).

DHCS requires MCPs to submit a texting program and/or its individual texting campaign approval form to the state. DHCS will review and respond within 60 days of submission of the form (See Attachment 7).

As indicated, staff will return to the Board to seek authority for approval of other elements of the Virtual Care Strategy in the future.

Fiscal Impact

The recommended action to approve the Virtual Care Strategy and Roadmap has no additional fiscal impact for Fiscal Year (FY) 2019-20. Staff will address new virtual care strategies including a vendor offering 24/7 virtual visits and a vendor offering eConsults in future board reports and recommended actions.

The recommended action to select and contract with mPulse, a mobile health interactive text messaging services vendor has no net fiscal impact to CalOptima's operating budget over the proposed project term. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures for the initiative recommended in this report.

Rationale for Recommendation

The recommended actions are important steps in enabling CalOptima to provide additional access to quality care for our members and providers during and after the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities
2. CalOptima Virtual Care Roadmap Presentation
3. Virtual Care Strategy Logic Model
4. Virtual Care Strategy Work Plan
5. 19-20 Texting RFP Final Team Evaluation Summary Scoring Criteria
6. Texting Program RFP Scope of Work
7. DHCS Texting Program & Campaign Submission Form
8. Board Action dated February 7, 2019, Consider Approval of CalOptima Population Health Management Strategy for 2019
9. Entities Covered by this Recommended Board Action

Reference
1. Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centered primary care: findings of a consensus policy dialogue using a nominal group technique. J Telemed Telecare 2018;24(9):608-15.

/s/ Richard Sanchez *04/29/2020*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact
David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions
1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)
One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

For 2020402 BOD Review Only

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

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D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

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i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

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2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

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in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, 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 Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

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1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group 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)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

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I. 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
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

For 2020 POD Review Only

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
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.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
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.
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.

For 2020

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

For 2020040 Preview Only

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

For 20200402 BOD Review Only

Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

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

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I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

Back to Agenda Back to Item

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

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a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, 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.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

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C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

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a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

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I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
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.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
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.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
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
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.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

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

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. Data Architect

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

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TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting **Feb. 2020 – Present**

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California **April 2017 – Feb. 2020**

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

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CalOptima
A Public Agency
Better. Together.

Virtual Care Strategy: Road Map to Increase Access to Care

Board of Directors Meeting

May 7, 2020

Sajid Ahmed, CEO WISE Healthcare, CalOptima Virtual Care Expert

Betsy Chang Ha, RN, MS, LSSMBB
Executive Director, Quality & Population Health Management

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On Strategy

"For some organizations, near-term survival is the only agenda item.

Others are peering through the fog of uncertainty, thinking about how to position themselves once the crisis has passed and things return to normal.

Crisis

危機

A time of danger

A time of opportunity

The question is, 'What will normal look like?' While no one can say how long the crisis will last, what we find on the other side will not look like the normal of recent years."

~ Ian Davis, 2009

During the Great Recession

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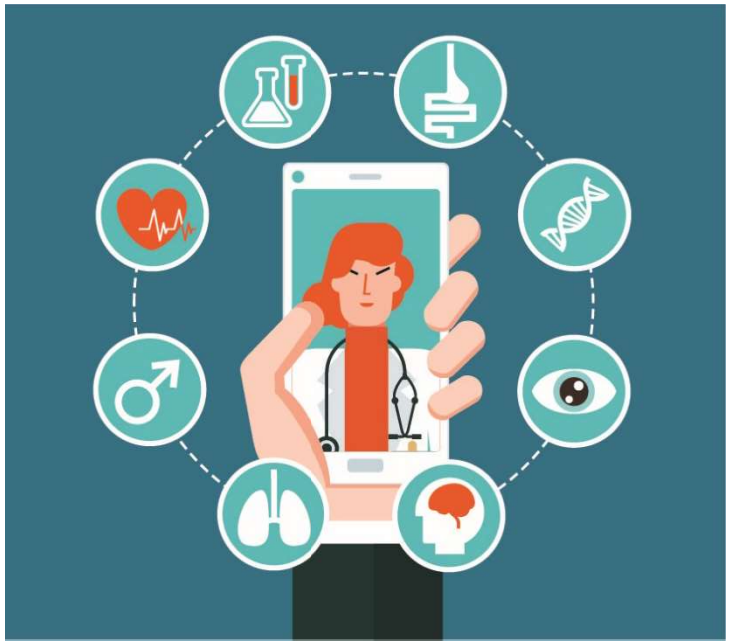
Agenda

- Traditional Barriers to Telehealth
  - Impact of COVID-19 on Regulations
- Virtual Care Definition (Telehealth)
- Virtual Care Modalities
- Virtual Care Roadmap Approach
  - Logic Model: Virtual Care Adoption for CalOptima
- The Future
  - Lifting of Barriers
  - Will They Stay or Will They Go Now?
- CalOptima Virtual Care Strategy



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Traditional Barriers

- Payment and compensation (Provided due to COVID-19)
- Disruptive to current workflow (Yes, post COVID-19)
- Got enough on my plate (COVID-19 response is priority)
- Their convenience, not mine (COVID-19 response is priority)
- New technology, learning (Not really but in some cases)
- Laws, rules, and regulations (Relaxed due to COVID-19)
- Liability questions (Telehealth Insurance now standard)

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Impact of COVID-19 on Regulations

- On March 11, 2020, the World Health Organization declared the COVID-19 outbreak a pandemic.
- On March 15, Health and Human Services issued a "limited waiver" of Health Insurance Portability and Accountability Act sanctions.
- On March 17, Centers for Medicare & Medicaid Services said it would expand Medicare coverage of telemedicine services.
  - CMS said Medicare will pay providers the same in-person rates for virtual visits with hospitals, doctors and other licensed clinicians […] regardless of the patients' location.
- And on and on ...

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Virtual Care Definition

- Beyond telehealth, Virtual Care is a broad definition encompassing any modality of remote technologically driven patient health care delivery, device use, monitoring and treatment.

- A recent paper offered the following definition of virtual care:
  - Any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care.

By Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centered primary care: findings of a consensus policy dialogue using a nominal group technique. J Telemed Telecare 2018;24(9):608-15.

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Virtual Care Modalities

	Real Time "Synchronous"	**Store and Forward** "Asynchronous"
Visits (Provider to Patient)	**Virtual Visit**  Video/telephonic visit between provider and patient	***e*Visit**  Online exchange (e.g., email or text) between provider and patient
Consults (Provider to Provider)	**Virtual Consult**  Video/telephonic consult between provider to patient's provider	***e*Consult**  Online consult between specialist to patient's local provider

Virtual Care **IS** care provided via phone, email, text, and video.
87% of all diagnostic decisions can be made via Virtual Care

Image courtesy of Sajid Ahmed at WISE Healthcare.

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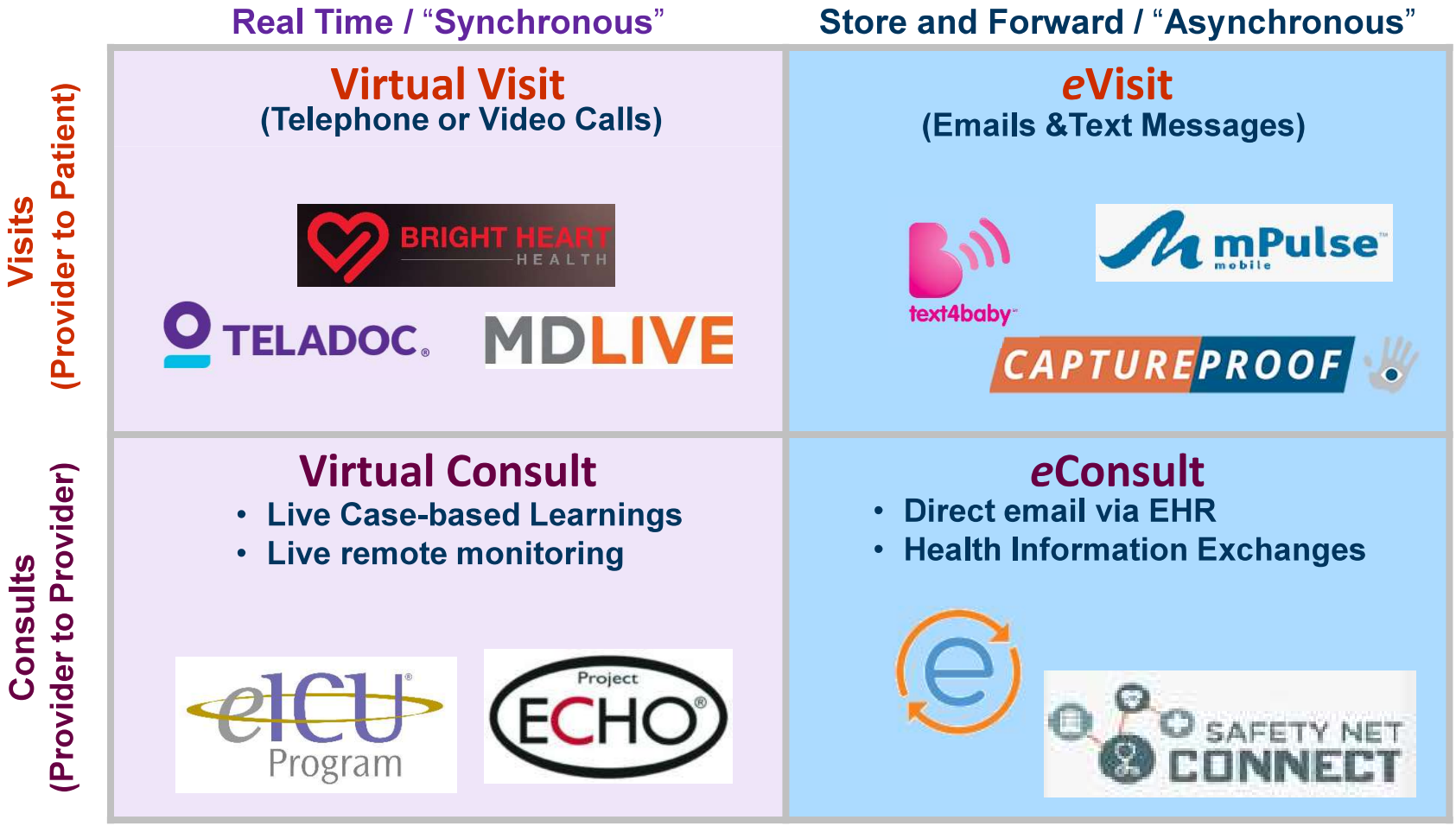
Examples of Virtual Care Modalities



Examples only. CalOptima does not endorse specific vendor.

Image courtesy of Sajid Ahmed at WISE Healthcare.

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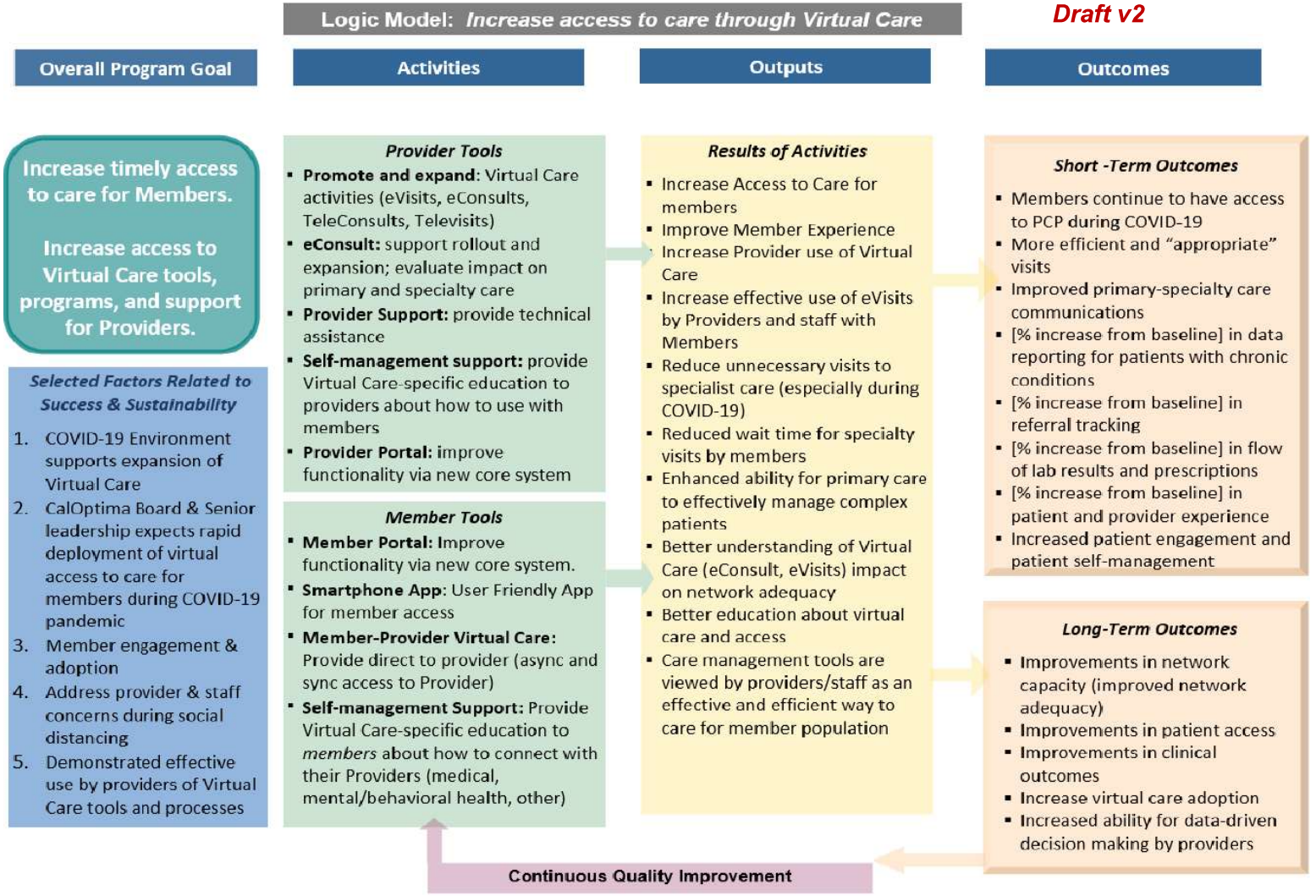
Logic Model: Increase Access to Care Through Virtual Care



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MCP Guidance for Use of Virtual Care by Members and Contracted Providers (cont.)

Member

- Member will use the provider-given cell number to **text** the provider with their reason to request a virtual visit (chief complaint, medical concern, follow-up visit).
- Provider and member will communicate back and forth using text messages (member to provider eConsult).
  - If member concerns are resolved at this stage, no further action is necessary.
- If the provider deems a phone **call** necessary, text messages will be used to coordinate the call.
  - With all stages of communication, the provider can use any location (home) as a responding site.
- If after the phone conversation the provider deems that a **video call** would be necessary, text messages are used to coordinate a video call.

Disclaimer: MCPs do not recommend, endorse, nor sponsor specific messaging applications nor cellular providers.

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MCP Guidance for Use of Virtual Care by Members and Contracted Providers

Due to COVID-19, select federal and state virtual care restrictions have been lifted — the use of smartphones and other communication applications to facilitate dialogue between providers and members has been approved. This communication will be allowed and reimbursable per CMS and DHCS directives.

Protocol: Providers and members can text, call and video call to coordinate and manage care to and from any location (home).



Providers



Providers will select a SMS text enabled cell number that can be used by patients. If possible, this can be the provider's primary cell number or:

- An app can be used that allows the provider to receive multimedia messages (WhatsApp, iMessage, Line, GroupMe, Google Duo, Arya, etc.)
- Providers can obtain a new cell number to be used for this purpose through any cellular carrier



Providers can designate a staff member to monitor communication with this number (possibly through a group chat) and facilitate member provider coordination.



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Every Cloud Has a Silver Lining...

- It took the COVID-19 pandemic to
  - Waive or relax most health care regulations to ensure that patients get the best possible care at the lowest possible cost, when and where they need it.
- The federal rules and regulations providing limited waivers due to the COVID-19 pandemic are:
  - **HIPAA sanctions waiver —** waiving patient consent
  - **Telemedicine reimbursement —** provided for all virtual care
  - **Physician scope of practice** — lets "all doctors and medical professionals to practice across state lines to meet the needs of hospitals that may arise in adjoining areas"
  - **Elective surgery guidance** — limits elective surgical and dental procedures for adults
  - **Quality reporting requirements —** suspended or extended

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Regulations: Will They Stay, or Will They Go?

- The outbreak shined a light on all the rules and regulations that the U.S. health care system operates under.
- Regulations and rules shown to be impediments to safe, effective, convenient, accessible and affordable care for members.
- CalOptima's long term Virtual Care strategy provides a roadmap to navigate the future in providing low-cost, high quality, timely access to care.

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Key Takeaways

- COVID-19 morphed virtual care into a powerful resource that enables the disruption of health care delivery.
- In-person care and virtual care are to be treated the same as appropriate. With virtual care expected to be the primary modality to access care in the future.
  - The “new normal”
- Leadership support is needed from the Board, Chiefs, physician champions, and Health Networks to achieve success and meet the challenges and opportunities of the health care “new normal”

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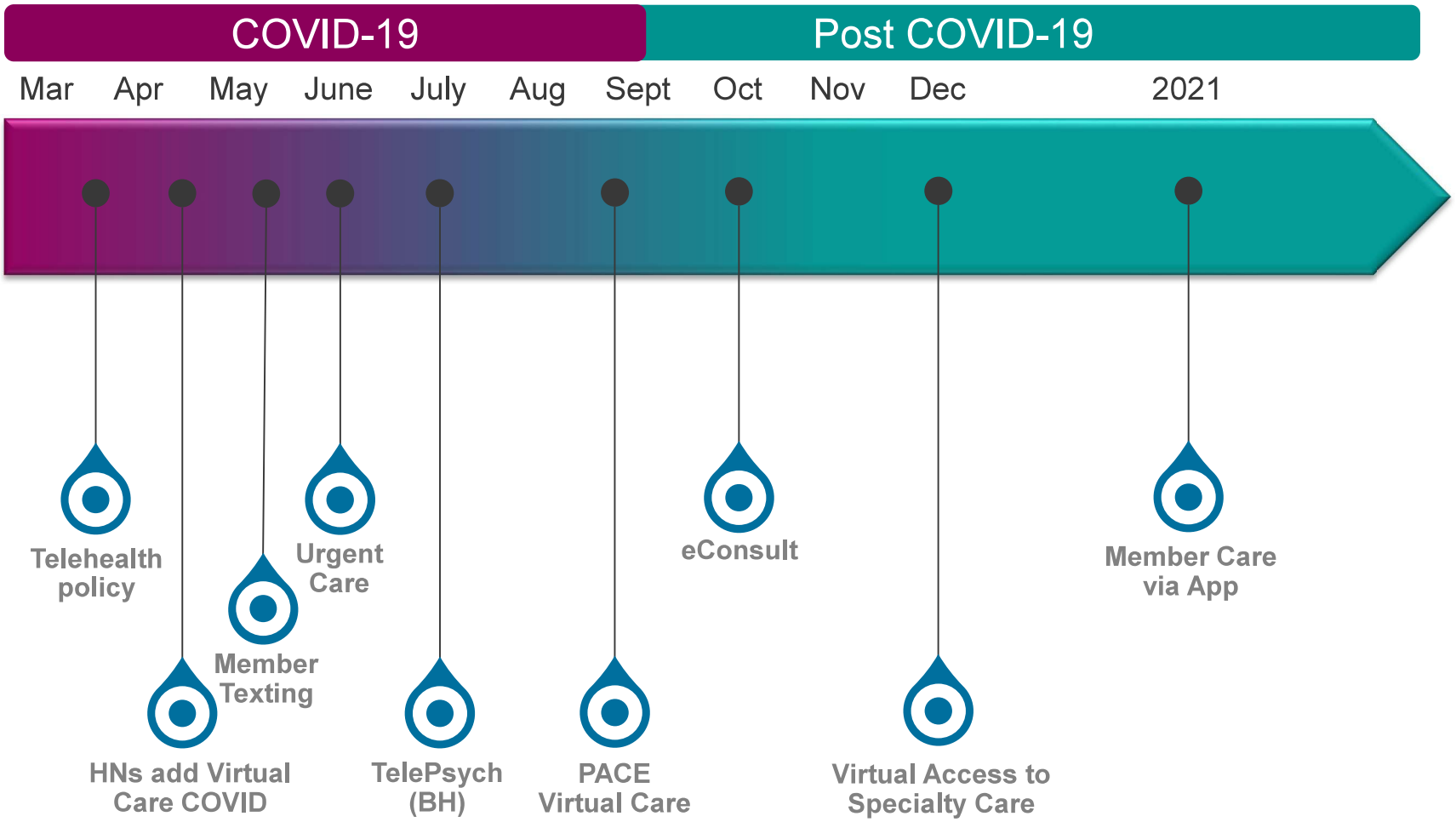
High Level Virtual Care Roadmap



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CalOptima Virtual Care Strategy (Road Map)

Board of Directors Regular Meeting

May 7, 2020

David Ramirez, M.D., Chief Medical Officer

Betsy Chang Ha, RN, MS, LSSMBB

Executive Director, Quality & Population Health Management

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Virtual Care Guiding Principles

- Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management;
- Leverage existing delivery model where possible;
- To be proactive in seeking out opportunities to innovate; and
- To provide technology-agnostic solutions.

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Proposed Initial Virtual Care Strategy: All Members (HN/CCN/COD)

Member to Provider		
Goals	**Use Existing Network Providers**	**Contract Vendor(s) to support limited scope of services during COVID-19**
Tasks	• Leverage existing capabilities • Guidance • Technical support • Technology agnostic	• Member self-referral via Member Portal (web) • Urgent care • Prescription management • Access to Behavioral Health
Time	Q1 2020	Initiate Contract in Q2–Q3 2020
Action	**Update Telehealth Policy (completed)**	**RFP (IGT 9) for vendor(s)**

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Proposed Initial Virtual Care Strategy: CalOptima Community Network & CalOptima Direct

	Member to Provider	Provider to Provider
Goals	**Provide Virtual Care:** Member access to Provider Group(s), eVisits to primary care and specialist services	**Implement eConsult (CCN)** (Provider to Provider) per DHCS APL 19-009 to provide eConsult as a covered benefit
Tasks	• Support existing physical primary care providers and specialists • Behavioral Health Services (for all members) • Expand specialty providers with a virtual care focus	• Prior Authorization process modified to allow eConsult to replace authorization • Make available to PACE as well • Provider self-service and submit authorization via Provider Portal and eConsult
Time	Selection in Q3 2020	Contract in Q4 2020
Action	**Evaluate telehealth providers/groups**	**Develop plan to implement eConsult**

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Virtual Care Roadmap Q2–Q4

High Level Activities

1. Member engagement approaches, app support and tools
2. Continue activities to support COVID-19 related items
3. Virtual Care technical platform for PACE
   - Facilitate provider-member virtual visits
4. Investigate and implement provider support and technical assistance
5. In progress:
   - Virtual Care Strategy and Roadmap
   - CalOptima Virtual Care Team
6. Expand specialty providers with a virtual care focus
   - Behavioral health and other specialties

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Virtual Care Roadmap Q2–Q4 (cont.)

High Level Activities (cont.)

7. Offer 24/7 virtual visits (after-hour access)
   - Acute non-emergency medical conditions
   - Behavioral health conditions
8. Investigate and implement CalOptima member engagement access via member portal app
   - APIs to virtual visits, eVisits, secure messaging
9. Plan and launch eConsult/eReferral program for CCN
10. Member texting
    - E.g. Text For Baby, notifications, alerts via CalOptima Smart app, e.g. IEHP Smart Care app
11. RFP for member direct to provider access
    - Member to provider

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Logic Model: *Increase access to care through Virtual Care*

Draft v2

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Overall Program Goal

Increase timely access to care for Members.

Increase access to Virtual Care tools, programs, and support for Providers.

Selected Factors Related to Success & Sustainability

1. COVID-19 Environment supports expansion of Virtual Care
2. CalOptima Board & Senior leadership expects rapid deployment of virtual access to care for members during COVID-19 pandemic
3. Member engagement & adoption
4. Address provider & staff concerns during social distancing
5. Demonstrated effective use by providers of Virtual Care tools and processes

Activities

Provider Tools

- **Promote and expand**: Virtual Care activities (eVisits, eConsults, TeleConsults, Televisits)
- **eConsult:** support rollout and expansion; evaluate impact on primary and specialty care
- **Provider Support:** provide technical assistance
- **Self-management support:** provide Virtual Care-specific education to providers about how to use with members
- **Provider Portal:** improve functionality via new core system

Member Tools

- **Member Portal:** Improve functionality via new core system.
- **Smartphone App**: User Friendly App for member access
- **Member-Provider Virtual Care:** Provide direct to provider (async and sync access to Provider)
- **Self-management Support:** Provide Virtual Care-specific education to *members* about how to connect with their Providers (medical, mental/behavioral health, other)

Outputs

Results of Activities

- Increase Access to Care for members
- Improve Member Experience
- Increase Provider use of Virtual Care
- Increase effective use of eVisits by Providers and staff with Members
- Reduce unnecessary visits to specialist care (especially during COVID-19)
- Reduced wait time for specialty visits by members
- Enhanced ability for primary care to effectively manage complex patients
- Better understanding of Virtual Care (eConsult, eVisits) impact on network adequacy
- Better education about virtual care and access
- Care management tools are viewed by providers/staff as an effective and efficient way to care for member population

Outcomes

Short -Term Outcomes

- Members continue to have access to PCP during COVID-19
- More efficient and "appropriate" visits
- Improved primary-specialty care communications
- [% increase from baseline] in data reporting for patients with chronic conditions
- [% increase from baseline] in referral tracking
- [% increase from baseline] in flow of lab results and prescriptions
- [% increase from baseline] in patient and provider experience
- Increased patient engagement and patient self-management

Long-Term Outcomes

- Improvements in network capacity (improved network adequacy)
- Improvements in patient access
- Improvements in clinical outcomes
- Increase virtual care adoption
- Increased ability for data-driven decision making by providers

Continuous Quality Improvement

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Cal Optima Virtual Care High Level Workplan	2020 - Phase IIA - Foundation (New Fiscal)									
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Member to Provider (eVisits / Televisits)										
Phase I: Member calls Provider Directly										
Phase II: Member calls Nurse Advice Line to Provider										
Phase III: Member uses CalOptima App to Provider										
Decision on Scope (HNs vs Direct)										
Procurement Process										
Compliance/Legal/Internal Review Process										
Contracting Process										
Implementaiton Process										
Policy and Procedure update										
Internal Operationalization										
Prepare COBAR and get Approvals										
Guidelines Onboarding										
Pre and GO Live activities										
Provider to Provider Virtual Care Support										
Decision on Scope (HNs vs Direct)										
Procurement Process										
Compliance/Legal/Internal Review Process										
Contracting Process										
Implementaiton Process										
Policy and Procedure update										
Internal Operationalization										
Prepare COBAR and get Approvals										
Guidelines Onboarding										
Pre and GO Live activities										

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TEAM SUMMARY SCORES
RFP 19-020 – Mobile Text Messaging Services

Proposals Scores

Vendor Name	Score
mPulse	3.57
HealthCrowd	3.45
Bluespire	3.63
TigerConnect	3.32
Medecision	3.19
MTX Group Inc.	3.17
Variedy	3.10
Care3	3.04

Interview Scores

Vendor Name	Score
mPulse	4.30
HealthCrowd	4.18
Bluespire	3.73
TigerConnect	2.51
Medecision	0.00
MTX Group Inc.	0.00
Variedy	0.00
Care3	0.00

Overall Scores

Vendor Name	Score
mPulse	3.94
HealthCrowd	3.81
Bluespire	3.68
TigerConnect	2.92
Medecision	3.19
MTX Group Inc.	3.17
Variedy	3.10
Care3	3.04

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M E M O R A N D U M

DATE:	May 22, 2019
TO:	Pshyra Jones, Ashley Young, Kelly Rex-Kimmet, Belinda Abeyta, Albert Cardenas, Erica Neal, Christine Sisil, Adriana Ramos, Edwin Poon, Diane Ramos, Lisa Ha
FROM:	Maria Medina, CPPB
SUBJECT:	RFP 19-020 – Mobile Text Messaging Services

EVALUATION PROCESS INSTRUCTIONS:

IMPORTANT….If you are contacted by any vendor regarding this RFP process, please do not speak with this vendor and forward all calls to my attention.

Step One: ***Review all Proposals***. Evaluation committee members were provided with copies of each RFP response to begin their individual review of the Proposals. **Take notes, make comments and/or prepare questions for discussion.** Do not score at this point.

Step Two: ***Determine status***. Make an initial determination as to whether each Proposal is "responsive" or "non-responsive." A "responsive" proposal conforms in all material respects to the RFP. A proposal may be deemed "non-responsive" if essential required information is not provided, the submitted price is found to be excessive or inadequate as measured by criteria stated in the RFP, or the proposal is clearly not within the scope of the project described and required in the RFP. *Extreme care should be used when making this decision because of the time and cost that a vendor has put into submitting a proposal. If a proposal is determined to be "non-responsive," it will not be considered further. The Purchasing department will make the final determination of responsiveness. If a determination of "non-responsiveness" is made, written justification must be provided for this conclusion.*

Step Three: ***Score proposals.*** Committee members should **INDIVIDUALLY** score the proposals based on the criteria established within the RFP. Please send me your individual scores by **12:00 Noon, June 5, 2019.** I will prepare a summary team score for all scorers.

Step Four: ***Evaluation Committee Meeting***. Once the proposals have been evaluated and scored by the individual committee members, the entire committee will meet to discuss the proposals and arrive at the final scoring. The committee should discuss all aspects of the proposals so that there is a "unified understanding" of the criteria and corresponding responses. Individual scores may be adjusted at this point based upon discussion. If any of the scores change I will prepare a new summary team rating. The highest score on the Summary Team score will be awarded the business.

Step Five: ***Discussion/Negotiation.*** This step is optional. If the committee is unsure of certain items or issues included in the RFP response, it may request further clarification from the vendor. The Purchasing department will distribute clarification questions to applicable vendor/s. Upon receipt of the vendor responses, the Purchasing department will distribute to the committee members.

Step Six: ***Best and Final Offer.*** This step is optional. A letter asking the vendors to submit a "Best and Final Offer" may be issued by the Purchasing department at the request of the evaluation committee. Once a "Best and Final Offer" is received, the committee will evaluate it in the same manner as the original Proposal.

Step Seven: ***Recommendation and Review.*** After the final scores from the above steps are tallied, the Purchasing department will contact the successful vendor and initiate the agreement process. Upon contract execution, the Purchasing department will notify the remaining vendors, informing them of our decision to award the business elsewhere.

PROPOSAL RATING INSTRUCTIONS:

The attached proposal evaluation form is to be used to initially rate and score proposals. Please enter your scores in the "raw score" fields of the Evaluation Score Sheet. *Please forward to my attention, an electronic version of your completed Evaluation Score Sheet no later than* ***12:00 Noon, June 5th****. The initial results will be presented at the meeting and will form the basis of our discussion.*

- EVALUATION CRITERIA

  Evaluation criteria and respective weights are as follows:

Evaluation Criteria	Raw Possible Points	Weight Factor	Total Possible Score
Letter of Transmittal Requirements, Proposal Organization, completeness of response	5	10%	0.50
Process: Vendor can perform all aspects of the Contract, knowledge of industry, proper qualifications, can handle our size and needs	5	25%	1.25
Related experience: Years, Worked with Vendors similar to CalOptima, References	5	20%	1.00
Account Team: Qualifications, Location, Experience	5	15%	0.75
Price	5	20%	1.00
Contract Changes (Purchasing Only)	5	10%	0.50

  With the four different evaluation criteria, there is a total of 30 "raw points" available for each Proposal. Each evaluation criteria has been weighted in proportion to its perceived value to the overall score.

  Each criterion should be rated separately from the others. In other words, if vendor "A" appears highly capable of effectively completing the project/providing the service, has very good qualifications and related experience, but in your opinion, does not have competitive rates, you should not downgrade your score for the first two criteria as punishment for not doing well on the other criteria categories. It is perfectly acceptable to give vendor "A", a higher score for the first two criteria, and a lower score on the other applicable criteria.

  The Evaluation Team will only need to input their scores in the rows entitled "raw score" of the attached electronic Evaluation Score Sheet.

- PROPOSAL CRITERIA RATINGS (0-5)

  Please rate each Proposal on a scale of 0-5 for each evaluation criteria. This scale and the meaning of the ratings are as follows:

  5 - Outstanding - far exceeds minimum requirements, offers prospects of extremely high-quality work product.

4 - Very Good - exceeds minimum requirements, offers prospects of very high work product.

3 - Good - meets minimum requirements, although there are deficiencies which may result in some flawed work products.

2 - Barely adequate - several deficiencies which may result in flawed work product.

1 - Deficient - does not meet requirements, poses virtual certainty of high risk of flawed products and generally inadequate performance.

0 - Totally non-responsive and noncompetitive to the RFP.

- SCORE (Maximum 5 points)

  Raw Possible Points Evaluation Rating x Weight/Factor = Total Possible Score
  The maximum weighted score for any given Proposal is 5 points.

Reminder….. The EVALUATION MEETING is scheduled for June 6th from 1:00pm – 2:00pm in conference room 802-S

I can be reached on ext. 8659 for any questions. Thank you.

Scope of Work

I. OBJECTIVE

CalOptima is seeking a CONTRACTOR to provide Mobile Text Messaging services to enhance member engagement. The successful Offeror must support CalOptima in implementing a secure communication program designed to close gaps in care, improve quality scores, drive higher engagement and satisfaction for CalOptima's members.

The successful Offeror will provide technology platform for managing outreach to CalOptima's members via text message. The interactive messages must operate as a reliable, secure, and high-speed messaging system of use in the health care environment.

II. MEMBERSHIP

CalOptima's membership is provided for reference only.

CalOptima Membership*

Program	Description	Members
Medi-Cal	California's Medicaid Program for low-income children, adults, seniors and people with disabilities	689,641
OneCare Connect	Medicare-Medicaid Plan for people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits, adding supplemental benefits for vision, transportation and dental services, and providing comprehensive care coordination	14,104
OneCare	Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal	1,417
PACE	Program of All-Inclusive Care for the Elderly for older adults, providing comprehensive health services through the CalOptima PACE center	394

**Membership Data as of January 31, 2020*

III. REQUIREMENTS

A. Comply with all state and federal regulations, including but not limited to FDA, Affordable Care Act (ACA), Centers for Medicare and Medicaid Services (CMS), the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **The Contractor shall be required to sign a Business Associate Agreement (BAA) prior to the commencement of the Contract.**

B. **MOBILE TEXT MESSAGING**

1. Text Campaign Strategy

   a. Successful Offeror's mobile text messaging services must be able to support specific initiatives to help increase member engagement and communications between CalOptima andthe member and. Please describe and/or provide any

samples to demonstrate how the Successful Offeror can support the following with targeted texting strategies:

- Quality Improvement (i.e. preferable experience in assisting health plans with improving HEDIS measures, preventive care, medication adherence, wellness, disease management, etc.)
- Health Plan Navigation Support (i.e. providing information on health care benefits, how to access CalOptima's programs or services such as Nurse Advice Line, assisting new enrollees on how to choose a doctor, etc.)
- Surveys to measure member satisfaction with CalOptima's services

2. Text Messaging Features
   a. Please describe the messaging features that are supported by the Successful Offeror. At minimum, they should include:
      - Text blasting/bulk messaging
      - Two-way text messaging
      - Tailored or personalized text messages
      - Automated responses
      - Keywork responses
      - Conditional branch logic (allow for keyword and automated responses based on predefined algorithm)
      - Message scheduling/staggering
      - Message queuing
      - Active links
      - Voting and polling
      - Short codes
      - Unicode support

3. Content

   a. Content must be written at a sixth-grade reading level or below to ensure the information is easy to understand. Please provide any details related to content development, required approvals, and customization options.

4. Enrollment

   a. Successful Offeror shall have policies and proecuedres for managing the users opt-out/opt-in and text preferences.

   b. Successful Offeror must be able to support CalOptima with identifying mobile numbers and land line numbers to distinguish users who are able to receive text messages.

IV. DATA EXCHANGE, SECURITY, AND SYSTEM INTERFACE REQUIREMENTS

A. The Successful Offeror must have a Health Insurance Portability and Accountability Act (HIPAA) compliant platform and secure encryption texting capability to ensure the safe management of Protected Health Information (PHI) and other sensitive data. Please share the process, policies and/or procedures Successful Offeror will follow to ensure HIPAA regulations are met and certified as HIPAA compliant.

B. Successful Offeror shall have the ability to handle eligibility files and to download from CalOptima's FTP site. It shall also have the ability to take the eligibility files and set-up a system load.

C. Successful Offeror must ensure that all data is kept for ten (10) years at minimum.

D. Successful Offeror agrees, upon termination of the relationship (regardless of which party terminates), to provide all information required for successful transition files at no additional cost.

V. CULTURAL AND LINGUISTICS

A. CalOptima supports seven (7) "threshold" languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese, and Arabic. Successful Offeror shall have ability to support mobile text messaging services in English and Spanish, at minimum. Please list any other languages that are supported by the Sum.

VI. REPORTING

A. Successful Offeror's reporting mechanisms should be able to provide real-time updates of text message delivery and campaign performance. Describe what information is captured on these reports.

B. Summary reports shall be provided at the conclusion of each text campaign that measures performance and outcomes. Describe the report features and the data elements that are captured.

C. Reports should be in a format that allows data to be integrated into CalOptima systems. How will data be shared with CalOptima (i.e. web portal, secure email, FTP transfer, etc)?

D. Does the Offeror include any analysis in the standard reporting package?

E. All offerors shall provide a sample copy of the reports with its proposals.

VII. SERVICE LEVEL AGREEMENT (SLA)

What Service Level Agreements and warranties does your company provide? Please provide detail levels and metrics. Include a specific time element offered.

VIII. IMPLEMENTATION SCHEDULE

Offeror shall provide an implementation timeline, including benchmarks and milestones as part of its response.

IX. PRICING MODEL

Offeror shall provide pricing model/structure for implementation, services provided and any other fees CalOptima may incur.

TEXTING PROGRAM & CAMPAIGN

SUBMISSION FORM

INSTRUCTIONS:
This form is required for all Medi-Cal managed care plans' (MCP) texting program and/or its individual texting campaign(s). Complete this form, including the Indemnification Agreement and email it to your DHCS Contract Manager for approval. DHCS will review and respond within 60 days of submission of the form.

Email subject line must include "For your approval: MCP name, Subplan name if applicable, Texting, and Campaign(s). For example:

- For a campaign submission: "For your approval: PlanA_Texting_New Member Orientation"
- For multiple campaigns submission: "For your approval: PlanA_Texting_Multiple Campaigns"

MCP is required to complete **all sections (Sections A-C)** when MCP first seeks an approval for a new Texting Program. Once MCP's new texting program has been approved and MCP would like to add additional campaigns, MCP will need to complete **Section A** and **Section C** only.

MCP can replicate **Section C** for additional campaigns if MCP desires to submit multiple campaigns for approval at the same time.

As a condition of approval for any text messaging campaign, a designee within the MCP who holds signatory authority is required to execute the attached Indemnification Agreement. Approval of the campaign is not considered final until the MCP receives a signed copy of the Indemnification Agreement back from the DHCS.

Key definitions

1. Texting Program: MCP's overall program design and infrastructure utilized to implement individual text messaging campaigns.
2. Texting Campaign: MCP's specific text message(s) aimed to address an identified objective (e.g., Preventive Care Reminders, New Member Orientation, etc.).

SECTION A: GENERAL INFORMATION

1. Managed Care Plan: _____ Date: _____
2. Submitted on behalf of a subcontracting MCP: _____ ☐ N/A
3. List the county or counties where you conduct your texting campaign(s):

   _____

SECTION B: TEXTING PROGRAM POLICY & PROCEDURE

1. Does the MCPs policy describe the process the MCP will use to obtain Members' Agreement to Participate (i.e., release of information) either through active opt-in or assumed opt-in approach and explain how a member can opt-out and the timeline associated with processing such requests? Please attach MCP's program policy and procedure (PnP) and process workflow. If no, please describe.

   ☐ Yes

   ☐ No

2. Does MCP's policy describe any financial costs that MCP's Members may incur from receiving the Agreement to Participate message(s) and any potential costs of future messages? If no, please describe.

   ☐ Yes

   ☐ No

3. Is the MCPs proposal related to redetermination outreach?

   ☐ Yes

   ☐ No

If yes, does the MCPs policy indicate outreach will only be made to members who are on the MCPs monthly 834 file showing an HCP status of 05?

☐ Yes

☐ No

4. Has the MCP provided texting script(s) to obtain MCP's Members' Agreement to Participate, or texting script(s) to allow MCP's members to opt-out?

☐ Yes

☐ No

5. Are the texting script(s) provided to members at the sixth grade reading level, per Exhibit A, Attachment 13, 4(C) of the contract with DHCS?

☐ Yes

☐ No

6. Does the texting script have any health education information? If yes, has the campaign script been reviewed and approved by the MCP health educator in accordance with APL 18-016?

☐ Yes

☐ No

7. Does the MCPs policy describe how the MCP considers privacy concerns and custody/guardianship situations based upon information available to MCP? If no, please describe.

☐ Yes

☐ No

8. Does the MCPs policy describe how the MCP protects Members' PII and/or PHI and meet requirements of Exhibit G of the contract with DHCS? If no, please describe.

☐ Yes

☐ No

9. Is the MCP using a third-party vendor? If yes, who is the vendor? If MCP has not already sent the vendor's Master Service Agreement and all contract amendments to DHCS, attach them to this application.

☐ Yes

☐ No

10. Does the vendor's Master Service Agreement comply with all applicable state and federal law and contract requirements in particular, Exhibit G of the contract with DHCS?

☐ Yes

☐ No

SECTION C: [SPECIFIC TEXTING CAMPAIGN NAME]

1. What is the overall purpose of campaign? Circle one.
   a. Providing health education information
   b. Providing written member information
   c. Reminding of preventive care visits
   d. Supporting statewide regulatory efforts on digital communications
   e. Other(s): _____

   Disclaimers: MCP certifies that any health education information provided through the campaign has been reviewed and approved by the MCP health educator in accordance with APL 18-016.

   Information on eligibility redetermination cannot be included in text campaign.

2. Describe the objectives of the campaign.

3. Does the campaign include any member incentives?

   ☐ Yes

   ☐ No

   If yes, has the incentive been reviewed and approved by DHCS health educators in accordance with APL 16-005?

   ☐ Yes

   ☐ No

4. Does the campaign include Personal Identification Information (PII) and/or Protected Health Information (PHI)? If yes, confirm the answer to question 7 in Section B above is checked "yes."

   ☐ Yes

   ☐ No

5. Who is the campaign's target population?

6. Who will be excluded from the campaign based upon information available to MCP (e.g., Members with SUDS, HIV/AIDS, behavioral health, minors in family planning, etc.)?

7. Does MCP require additional Members' Agreement to Participate for this specific texting campaign (i.e., extra opt-in requirement for sensitive services or PHI/PII content)?

   ☐ Yes

   ☐ No

8. What is the campaign length? When will it start and end?

9. What is the frequency of text messaging?

10. In what language(s) will the campaign be available? Will members have an option to receive text messages in their primary language (i.e. Spanish)?

11. Provide content script of the campaign.

12. What is the expected outcome of the campaign?

Attestations:

☐ For new campaign submission only (Section C), MCP attests that the Texting Program submission (Section B) that was previously approved contains no changes. Each new campaign will require an executed Indemnification Agreement.

☐ For ongoing texting programs, MCP will report to the DHCS Contract Manager the outcomes of plan texting campaigns on an annual basis, 45 days from the annual anniversary of the campaigns initiation. For time-limited campaigns, MCP will report outcomes six months after a program ends.

FOR DHCS USE ONLY (OR USE ALTERNATE DHCS AIR FORM)

1. DHCS Reviewer's Name: _____ Date: _____
2. DHCS Reviewer's Title: _____
3. DHCS Reviewer's Decision:

☐ Approved as submitted

☐ Approved with the following changes:

_____

☐ Denied

Reason (s): _____

_____

☐ Request for more information: _____

_____

_____

TEXT MESSAGING CAMPAIGN INDEMNIFICATION AGREEMENT

In consideration of the Department of Health Care Services' approval of [INSERT HEALTH PLAN NAME's] text messaging program, [INSERT HEALTH PLAN NAME] agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred to the extent DHCS is required to provide notice to affected beneficiaries and any other costs associated with any actual or alleged breach of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 and the Information Practices Act, California Civil Code section 1798 et seq. by [INSERT HEALTH PLAN NAME] and any vendor, contractor, subcontractor that [INSERT HEALTH PLAN NAME] contracts with for the approved text messaging campaign.

_____	_____
Health Plan Representative	DHCS Contract Manager
_____	_____
Date	Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, R.N., Executive Director, Quality and Population Health Management, (714) 246-8400
Edwin Poon, Ph.D., Director, Behavioral Health Services, (Integration) (714) 246-8400

Recommended Action

Recommend Approval of the Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Program for the Measurement Period effective January 1, 2021 through December 31, 2021.

Background

Behavioral Health Treatment (BHT) is a Medi-Cal covered service under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for members under 21 years of age. From 2014 to 2017, CalOptima Medi-Cal Behavioral Health (BH) benefits, including BHT services, were delegated to a Managed Behavioral Health Organization (MBHO). In 2018, CalOptima integrated Medi-Cal BH benefits within CalOptima internal operations. Currently, approximately 3,000 CalOptima Medi-Cal members receive BHT services each year.

Applied Behavior Analysis (ABA) is a type of BHT service. It has been identified as an evidenced-based approach for preventing or minimizing the adverse effects of behaviors that interfere with learning and social interaction. ABA therapy is intense, with treatment hours averaging 9 to 10 per week. The course of treatment can last for several years or longer. Most of the direct services are rendered by paraprofessionals who are unlicensed and require ongoing supervision. The education requirements for paraprofessionals are high school diploma, a minimum of 40 hours of training, and a demonstrated competency in implementing ABA intervention.

Since the Department of Health Care Services (DHCS) implemented the BHT benefit in 2014, CalOptima has followed the State Plan Amendment (SPA 14-026) regarding the types of providers allowed to supervise paraprofessionals:

1. Board Certified Behavior Analyst (BCBA)
2. Behavior Management Consultant (BMC)
3. Behavior Management Assistant (BMA)
4. Board Certified Assistant Behavior Analyst (BCaBA)

BCBA and BMC are considered the top tier supervisor types, while BMA and BCaBA fall under the mid-tier level. When a paraprofessional is supervised by a mid-tier provider, a BCBA or BMC is still required to oversee the work to ensure quality of care.

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In 2018, CalOptima proposed to phase out the mid-tier level (BMAs and BCaBAs) within a one-year period. The rationale for phasing out mid-tier was to raise the overall quality of care and align our approach with most commercial insurance plans and the Regional Center of Orange County. At that time, ABA providers expressed concerns over lack of available BCBAs and the associated cost. As a result, CalOptima has continued to maintain the 3-Tier model approach. Currently, approximately 50% of supervisions are conducted by the mid-tier level supervisors.

During the 2019 DHCS medical audit, file review showed some ABA providers were not providing the hours as stated in individual members' treatment plans. DHCS noted that when ABA providers insufficiently deliver direct service hours, members may not receive effective treatment and consequently, the quality of care may be compromised. DHCS recommended that CalOptima update and implement policies and procedures to monitor and ensure that ABA providers are providing BHT services based upon approved treatment plans, including providing direct service hours as authorized. Since then, CalOptima has developed a monitoring tool to track utilization of ABA direct services. Data reports show that the recommended hours authorized are not being fully utilized. Currently, on average, approximately 41% of authorized hours are being utilized. The DHCS medical audit findings also support the assumption that utilizing only top-tier level for supervision and monitoring of the ABA providers will help promote member and family-centered treatment planning, ensure appropriate utilization of direct service hours, and improve member experience with the ABA services. Currently there are no HEDIS or standardized measures for the quality of BHI ABA services

Discussion

In an effort to improve the quality of ABA services, CalOptima staff proposes to implement a Pay for Value (P4V) program designed to address the quality issues mentioned above. CalOptima has had good success with P4V programs targeting medical care both at the Health Network (HN) and individual provider levels. With CalOptima directly managing BH Services, there is an opportunity to leverage the same P4V program success to improve ABA services.

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting ongoing improvement that strengthens CalOptima's mission of providing members with access to quality health care. Annually, CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis includes evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, staff analyzes the difficulty of improving a measure due to the size of the eligible population or difficulty in data gathering. Finally, staff evaluates any changes to the specifications of the measures that are important to CalOptima's NCQA Accreditation status and/or overall Health Plan Rating.

The purpose of CalOptima's P4V program for the Health Networks, including the CalOptima Community Network (CCN), is consistent with the P4V programs of the previous years, which remains:

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1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks and physicians on their quality improvement efforts.

With CalOptima directly managing BH services, there is an opportunity to leverage the same P4V program success to improve ABA services.

The BHI ABA P4V Program is designed to improve quality of care, result in better individualized treatment recommendations, consistent treatment delivery, and decrease member grievances. Since there are currently no HEDIS or standardized measures for the quality of BHI ABA services, staff recommends that the program focus on two measurable objectives associated with quality of care:

1. Increase in the percentage of BCBAs supervising ABA services.
2. Increase in the percentage of authorized hours that members receive.

The baseline period will be January 1, 2020 to December 31, 2020 and the measurement period will be January 1, 2021 to December 31, 2021, with providers to be paid within 90 days of the close of the measurement year, by the end of March 2022. To earn the incentive, ABA providers will need to reach the target goals for each measure, which are set at four levels. The incentive will be calculated based on the level they reach, with a corresponding percent of annual claim paid amount. The maximum combined incentive will be no more than 4% of the provider's annual claims payment. Each ABA provider will receive a monthly report during the measurement year to evaluate their progress. Below are the specifications of the two proposed measures:

Measure 1

$$\%\text{ of supervision hours completed by BCBA/BMC} = \frac{\text{Total H0032* HO** hours per month}}{\text{Total H0032 per month}}$$

* H0032 is the CPT code for supervision
** HO is the modifier code for BCBA

Incentive Level	1	2	3	4
Measure Target Goal	50.00%	65.00%	80.00%	95.00%
Incentive by annual claims paid	0.50%	1.00%	1.50%	2.00%

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Measure 2

% of authorized 1:1 hours provided = $\frac{\text{Total number of 1:1 claims paid}}{\text{Total number of authorized 1:1 hours}}$

Incentive Level	1	2	3	4
Measure Target Goal	See Table below			
Incentive by annual claims paid	0.50%	1.00%	1.50%	2.00%

			1	2	3	4
Baseline rate			**Target Goal**			
70%	and	up	72.50%	75.00%	77.50%	80.00%
65%	to	69%	68.75%	72.50%	76.25%	80.00%
60%	to	64%	65.00%	70.00%	75.00%	80.00%
55%	to	59%	61.25%	67.50%	73.75%	80.00%
50%	to	54%	57.50%	65.00%	72.50%	80.00%
45%	to	49%	53.75%	62.50%	71.25%	80.00%
40%	to	44%	50.00%	60.00%	70.00%	80.00%
0%	to	39%	46.25%	57.50%	68.75%	80.00%

Incentive Payout Examples:

Provider A: Achieves Measure 1 and 2 target goals

	Measure 1	Measure 2
Y2020 Baseline Rate	40%	38%
Y2021 Measurement Rate	50%	46.25%
Incentive by Annual Claims Paid	**0.50%** (Level 1)	**0.50%** (Level 1)

Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022

Provider B: Achieves only one target goal

	Measure 1	Measure 2
Y2020 Baseline Rate	30%	60%
Y2021 Measurement Rate	48%	72%
Incentive by Annual Claims Paid	0% (did not meet target minimum)	**1.00%** (Level 2)

Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022

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Fiscal Impact
The recommended action to approve the Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Program is a budgeted item under the Board-approved Fiscal Year 2020-21 Operating Budget and is estimated not to exceed $600k for the six months of January through June 2021. Management will include expenses related to the remainder of the measurement period in future operating budgets.

Rationale for Recommendation
Based on two measurable performance metrics, the proposed behavioral health P4V program is intended to improve quality by incentivizing applied behavioral analysis (ABA) providers to increase BCBA/BMC supervision of the delivery of ABA services and move toward a two tier supervision model, and ensure that members receive the appropriate number of necessary and authorized ABA hours.

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

Attachments
1. ABA P4V Presentation 9/16/2020

/s/ Richard Sanchez *09/23/2020*
Authorized Signature **Date**

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Behavioral Health Applied Behavior Analysis Pay for Value Performance Program

Quality Assurance Committee Meeting

September 16, 2020

Edwin Poon, Ph.D., Director, Behavioral Health Integration

Donald Sharps, M.D., Medical Director, Behavioral Health Integration

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Agenda

- Activities and Timeline
- Background
- Discussion
- Proposed Performance Measures and Rationale
- Framework and Fiscal Impact
- Oversight and Stakeholder Engagement

Activities and Timeline

- Finance Review — Completed May 26
- P4V Steering Group — Completed June 29
- Executive Staff Meeting — Completed July 14
- Stakeholder Meeting — Completed August 7
- QIC Meeting — August 11
- QAC Meeting — September 16
- BOD Meeting — October 1

Background

- Behavioral Health Treatment (BHT) includes Applied Behavior Analysis (ABA).
  - Under 21 years of age
  - 2014 — Only if diagnosed with Autism Spectrum Disorder (ASD)
  - 2017 — Included non-ASD (typically intellectual disability)
- Board Certified Behavioral Analyst (BCBA) conducts Functional Behavioral Assessment (FBA) and develops treatment plan.
- Paraprofessionals conduct in-home training and behavior intervention services.
- ABA service is an intensive and long-term therapy.
- Service is renewed every six months.

Discussion: Supervision

- Follows the State Plan Amendment (SPA 14-026)
- Types of supervisors:
  - Board Certified Behavior Analyst (BCBA)
  - Behavior Management Consultant (BMC)
  - Behavior Management Assistant (BMA)
  - Board Certified Assistant Behavior Analyst (BCaBA)
- Supervision Models: 2-Tier vs. 3-Tier
  - 9 of 10 Medi-Cal managed care plans allow 3-tier
  - Three of six commercial plans allow 3-tier

Discussion: Supervision (cont.)

- Initially proposed 100% supervision by BCBA or BMC (2-Tier Model)
  - CalOptima accepted 3-Tier Model, if BCBA supervises all cases

2-Tier	3-Tier
BCBA or BMC	BCBA or BMC
Paraprofessional	BMA or BCaBA (mid-tier)
	Paraprofessional

Discussion: Under Utilization

- ABA Utilization vs. Authorization

All ABA Providers

Authorization Start Date : 2019-06 to 2019-11
Claim Date of Service : 01/01/2018 and onwards

Diagnosis	ABA Code Category	Procedure Code	Modifier	Avg. Auth Units Requested	Avg. Auth Units Authorized	Avg. Auth Units Utilized	% of Units Utlilized
non-ASD Dx	One-on-One	H2019		561	561	242	43%
			HM	672	672	0	0%
			HO	957	957	826	86%
ASD Dx	One-on-One	H2019		684	684	373	54%
			HM	1,207	1,207	234	19%
			HO	877	877	394	45%
Average Total				826	826	345	41%

ABA Code Category
- [ ] FBA
- [x] One-on-One
- [ ] Parent Consultation
- [ ] Social Skills
- [ ] Supervision

Diagnosis
- [x] ASD Dx
- [x] non-ASD Dx

FROM_Auth Start Date (... 2019-06

TO_Auth Start Date (all ... 2019-11

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Proposed Performance Measures

- **Metrics**
  - **% of supervision hours completed by BCBAs/BMCs**
  - **% of 1:1 hours provided vs recommended**
- We want to make sure the highest quality of supervision is being provided.
- Data show intervention recommendations and what is delivered are not equivalent.

Rationale for Recommendation

- Metric #1: To increase percentage of BCBAs/BMCs supervising cases
  - ABA providers do use 100% BCBAs for other commercial plans that require this.
  - They may increase number of BCBAs supervising CalOptima cases with incentive.
  - Improve quality, decrease impairments and comply with state plan amendment (SPA).

Rationale for Recommendation (cont.)

- Metric #2: To increase percentage of hours utilized vs authorized
  - ABA providers may increase/maintain paraprofessional staffing as this has been reason given for not utilizing hours authorized.
  - They may more individualize the treatment recommendations rather than literature-based numbers.

ABA P4V Framework

- 81 contracted ABA providers*
- Framework: 4 Tier of Payout
- Measurement year: CY2021
- Payout: Q1 2022

Projected Percent of ABA Cases per Tier

Tier	% of Cases	Payout by Tier	Total Payout
Tier 1	40%	1%	0.4%
Tier 2	30%	2%	0.6%
Tier 3	20%	3%	0.6%
Tier 4	10%	4%	0.4%
TOTAL			**2.0%**

*Exception Kaiser

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ABA P4V Framework (cont.)

- Metric #1: % of supervision hours completed by BCBA/BMC

Annual Percentage P4V			
0.5%	1.0%	1.5%	2.0%
Goal rate for P4V			
50.00%	65.00%	80.00%	95.00%

- Metric #2: % of 1:1 hours provided vs. recommended

Annual Percentage P4V

Base rate			0.5%	1.0%	1.5%	2.0%	Increase to reach next level
			Goal rate for P4V				
70%	and	up	72.50%	75.00%	77.50%	80.00%	2.50%
65%	to	69%	68.75%	72.50%	76.25%	80.00%	3.75%
60%	to	64%	65.00%	70.00%	75.00%	80.00%	5.00%
55%	to	59%	61.25%	67.50%	73.75%	80.00%	6.25%
50%	to	54%	57.50%	65.00%	72.50%	80.00%	7.50%
45%	to	49%	53.75%	62.50%	71.25%	80.00%	8.75%
40%	to	44%	50.00%	60.00%	70.00%	80.00%	10.00%
0%	to	39%	46.25%	57.50%	68.75%	80.00%	11.25%

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ABA P4V Incentive Payout — Example

- Provider A — Achieves Measures 1 and 2 target goals

	Measure 1	Measure 2
Y2020 Baseline Rate	40%	38%
Y2021 Measurement Rate	50%	46.25%
Incentive by Annual Claims Paid	0.50% (Level 1)	0.50% (Level 1)
Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022		

ABA P4V Incentive Payout — Example (cont.)

- Provider B — Achieves only one target goal

	Measure 1	Measure 2
Y2020 Baseline Rate	30%	60%
Y2021 Measurement Rate	48%	72%
Incentive by Annual Claims Paid	0% (did not meet target minimum)	1.00% (Level 2)
Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022		

Preliminary Fiscal Impact

MAX	4.0%
Projected Payout (of 4%)	50.0%
Annual ABA Spend (~)	$48,000,000
Annual P4V Spend	$960,000
FY21 (6-months Jan–Jun ’21)	**$480,000**

Oversight and Stakeholder Engagement

- Oversight:
  - ABA P4V performance monitoring will fall under the same structure currently designed for Pay for Value
    - Generated Prospective Rate Reports (Dashboard)
    - Providers will be able to track their progress on each Pay for Value measure during performance measuring period.
  - Next steps
    - Determine delivery method and frequency
    - Support for provider inquiries
- Stakeholder Engagement:
  - August 7 — ABA Council
    - Feedback received
  - Q4 ABA Council — TBD

Our 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 October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

Emily Fonda, M.D., Deputy Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to:

1. Remove the Medi-Cal (MC) line of business effective January 1, 2021; and

2. Extend the contract for provision of services for the OneCare, OneCare Connect and PACE lines of business through December 31, 2024.

Background

As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of a network of contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

Effective January 1, 2021, the Department of Health Care Service (DHCS) is "carving out" the pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to a fee-for-service program administered at the state level. "Medi-Cal Rx" is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the fee-for-service delivery system. Therefore, effective January 1, 2021, MedImpact services will include administering pharmacy benefits for CalOptima's OneCare, OneCare Connect and PACE programs only.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's PBM effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year term expired on December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. Rather than exercising the second one year extension option, the parties agreed to a two year extension, and at the Board's August 1, 2019 meeting, it approved the two year extension, effective January 1, 2020 through December 31, 2021.

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Discussion

Because of the complexity of the process and range of services provided, management estimates that a full replacement of CalOptima's PBM system would take over one year to complete, including the RFP process. It would require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives, and the process would need to begin by February 2021 at the latest. Furthermore, with the new Medi-Cal Rx program starting January 1, 2021, pursuing a PBM RFP with a potential PBM transition would cause significant disruptions for CalOptima providers.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.0 stars for 2020.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts annual audits of MedImpact. The purpose of the annual audits is to monitor PBM performance and ensure that CalOptima's pharmacy related obligations are being met satisfactorily for the Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC, CMS and DHCS regulatory requirements. CalOptima's annual audits of the PBM are comprised of two components: offsite and onsite. The offsite portion is performed as a desk review and the onsite portion takes place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate identified deficiencies.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for three years, through December 31, 2024 for the lines of business where CalOptima is responsible for ensuring that members have access to pharmacy services. Staff also recommends, in conjunction with the transfer of Medi-Cal pharmacy benefit management services to the state, to amend the contract to remove the Medi-Cal line of business since this function is being carved out by the state effective January 1, 2021. Staff have worked with MedImpact to develop a transition plan to ensure administrative obligations are met for the Medi-Cal Rx program requirements.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Consolidated Operating Budget approved by the Board on June 4, 2020 includes funding for pharmacy benefit management fees through the end of the fiscal year for the OneCare, OneCare Connect and PACE lines of business. The budget assumes the removal of the Medi-Cal line of business effective January 1, 2021. The recommended action to extend the MedImpact contract through December 31, 2024 is not expected to have any additional fiscal impact in the current fiscal year. Administrative fees paid to MedImpact for the OneCare, OneCare Connect and PACE lines of business will remain the same. Management plans to include funding for pharmacy benefit management fees for the remaining lines of business for the period of July 1, 2022, through December 31, 2024, in future operating budgets.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional three years, for the period of July 1, 2022, through December 31, 2024 with the elimination of the Medi-Cal line of business based on the DHCS's decision to transition to the Medi-Cal Rx model administered at the state level.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract
5. Board Action dated August 6, 2020; Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

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

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
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Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
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Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration, Inc.

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

Recommended Action
Ratify actions by the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a data sharing agreement with Magellan Medicaid Administration, Inc. (Magellan) to effectuate the transfer of Medi-Cal Pharmacy Benefit data, including those related to the Whole Child Model, to the State of California.

Background
On January 7, 2019, Governor Gavin Newsom signed Executive Order N-01-19 that will transition management of Medi-Cal pharmacy benefits from the Medi-Cal Managed Care Plans (MCPs), including CalOptima, to a Fee-for-Service Pharmacy Benefits Manager (PBM) directly contracted with the State of California (State). The State selected Magellan as its PBM through a competitive Request for Proposal process, with the contract awarded in December 2019. The transition is part of an effort to mitigate high prescription drug costs. Upon implementation, the state managed program—called Medi-Cal Rx—is designed to simultaneously provide cost savings and increased access through a wider, state-wide pharmacy network, as well as to standardize pharmacy benefits for all Medi-Cal beneficiaries, including those receiving services through California Children's Services, which is referred to as the Whole Child Model in Orange County.

Medi-Cal Rx is slated to go into effect on January 1, 2021, with approximately 11 million Medi-Cal beneficiaries to be moved over to the new carve out benefit statewide. The transition impacts all MCPs across the state, with the exception of the Program of All-Inclusive Care for the Elderly (PACE). Under the new structure, the State will assume the majority of management activities related to pharmacy benefits administration. MCPs will be responsible for activities including, but not limited to:

- Overseeing and maintaining all activities necessary for enrolled Medi-Cal beneficiary care coordination and related activities, consistent with contractual obligations.
- Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
- Processing and payment of all pharmacy services billed on medical and institutional claims.
- Participating in meetings related to the Medi-Cal Global Drug Utilization Review Board and other DHCS-driven pharmacy committee meetings.

Discussion
Staff requests that the Board ratify the execution of Magellan's Data Sharing Agreement ("Magellan Agreement") to facilitate a seamless and efficient PBM transition.

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As of January 1, 2021, Medi-Cal Rx will take over the responsibility from MCPs for administering the following when billed by a pharmacy on a pharmacy claim: Covered Outpatient Drugs including Physician Administered Drugs, Medical Supplies, and Enteral Nutritional Products.

As part of the transition, which is currently in progress, DHCS is facilitating data transfer of pharmacy information between MCPs, including CalOptima, and Magellan, the State's new PBM. This data includes claims, prior authorization, and other necessary benefit utilization information. To obtain authorization for data transfer, Magellan distributed a Data Sharing Agreement to all MCPs on June 8, 2020, requiring signature by July 2, 2020. Based on confirmation from the DHCS that MCPs were required to sign the Magellan Agreement, CalOptima staff signed the document on July 2, 2020, accommodating Magellan's target effective date of July 15, 2020 when data sharing was set to begin.

To effectuate the transfer of pharmacy data as required by the Magellan Agreement, CalOptima was also required to sign a Data Authorization Request form with MedImpact, CalOptima's PBM, for CalOptima's members. Through this form, CalOptima consented to the release of CalOptima member pharmacy information to Magellan. For CalOptima members receiving care under CalOptima's full-service Kaiser HMO Health Network arrangement, pharmacy benefits are provided directly from Kaiser rather than through MedImpact. Therefore, Kaiser will separately provide members' pharmacy encounter and prescription data to Magellan. DHCS approved Kaiser's direct transfer of pharmacy encounter and prescription data to Magellan. Accordingly, CalOptima, approved Kaiser's request to share member pharmacy information directly with Magellan.

Fiscal Impact
The recommended action to ratify execution of the Magellan Agreement is budget neutral.

Rationale for Recommendation
Ratification of the Magellan Agreement and related implementing documents was approved by DHCS and is required in order for CalOptima to share pharmacy data with the Magellan, DHCS's selected pharmacy benefit manager.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. DHCS Publication_Pharmacy Services Transition

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Elizabeth Lee, Director, PACE, (714) 246-8400
Bridget Kelly, Director, Communications, (714) 246-8400

Recommended Action

Appropriate up to $228,000 in unbudgeted funds from existing reserves and authorize the Chief Executive Officer to make expenditures of these funds to support enhanced marketing efforts for CalOptima PACE through June 30, 2021.

Background

CalOptima PACE was established in 2013 and currently serves approximately 385 participants via the CalOptima PACE Center and four operating alternative care settings (ACS) sites. PACE is a nursing home alternative for individuals requiring nursing home level care, but who are able to continue living in the community safely with appropriate support and assistance. The average age of PACE participants is 73 years.

CalOptima PACE enrollment has increased from 299 in early 2018 to 393 at the start of 2019. CalOptima PACE has exemplary health outcomes and has received awards, including the #1 participant satisfaction rating among PACE organizations in California and recognition from the National PACE Association as a "shooting star" and "supernova" for growth and access to PACE. CalOptima PACE ranks among the top PACE programs both in the state and nationally.

Per the PACE 2019 Quality Improvement Plan Evaluation, less than 1% of CalOptima's PACE participants resided in long-term care. It also reports that vaccination rates for pneumococcal and influenza were 95% and 97%, respectively. The FY 2020-21 CalOptima PACE operating budget projects revenue of $42.2 million, medical expenses of $37.7 million, administrative expenses of $2.0 million, and an operating margin of $2.5 million.

On April 4, 2019, the CalOptima Board of Directors took action to direct the CalOptima Chief Executive Officer to provide letters of support after consideration of requests for letters of support from AltaMed Health Services Corporation (AltaMed) and Innovative Integrated Health (IIH). Based on that board action, letters supporting AltaMed's and IIH's applications to establish independent PACE organizations in Orange County were sent to the Department of Health Care Services (DHCS) following staff's review of the requests. DHCS has received approval to expand PACE in Orange County, and AltaMed and IIH are in the application process. Assuming these applications are approved and AltaMed and IIH commence operations, CalOptima will no longer be the sole PACE facility operating in Orange County and will be have to modify its marketing strategy to retain current PACE participants and obtain new enrollment.

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DHCS notified CalOptima on August 6, 2020, that the Centers for Medicare & Medicaid Services (CMS) approved California's request to amend its Medi-Cal 2020 section 1115(a) Demonstration Waiver to expand PACE in Orange County. CalOptima was also notified that AltaMed's application to operate a PACE organization in Orange County was accepted and is currently under review, with operations expected to commence in January 2021. Approval of the application will result in a Medi-Cal contract between AltaMed and DHCS, separate from CalOptima. Staff also understands that IIH has submitted an application to operate PACE in Orange County.

All 24 ZIP codes included in the AltaMed application and 44 ZIP codes in the IIH application overlap with CalOptima's PACE service area, which includes all of Orange County. National PACE Association projections, based on US Census Data in 2019, estimate that the total number of individuals in Orange County who are potentially eligible to enroll in PACE is approximately 6,000. Nationwide, market penetration of eligible individuals enrolling in PACE is approximately 10–15% for mature PACE organizations.

Discussion

With more than one provider of PACE services soon to be operating in the same geographical area, CalOptima must now shift its approach to operating PACE in a competitive market, including changes to how CalOptima markets the PACE program. With respect to participant enrollment, CalOptima's marketing efforts have traditionally focused on the general PACE model rather than on CalOptima's PACE brand. CalOptima will need to refine its marketing approach to the same standard and presence as independent PACE Organizations (PO). CalOptima staff proposes to launch an enhanced marketing campaign focused on the following:

1. Membership retention
2. Year-round presence
3. Increase direct mail
4. Update collateral materials
5. Television/video

With respect to retention, PACE participants are permitted to change enrollment from one PO to another PO within their service area. CalOptima staff intends to incorporate value-added medically necessary services for CalOptima PACE participants to focus on retention in 2021 PACE Quality Initiative Plan.

Additionally, PACE personnel require specific training and qualifications to engage in direct care. Staff will have more PO employment opportunities in Orange County, creating a potential impact on recruitment and retention of CalOptima PACE employees. Staff plans to recommend future Board action to implement a competitive strategy to engage and retain PACE personnel.

CalOptima PACE exemplifies quality and efficiency, as evidenced by the #1 ranking PACE program in California for participant satisfaction, as well as national recognition for creating access to care for elderly beneficiaries. CalOptima PACE is an example of a successful public-private partnership and as a responsible steward of public funds.

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The CalOptima Fiscal Year (FY) 2020-21 Operating Budget included $363,000 for PACE public activities, member communication and advertising. Staff recommends authorization for an additional $228,000 to support enhanced marketing efforts.

Fiscal Impact
The recommended action is an unbudgeted item. As proposed, an allocation of up to $228,000 from reserves will fund this action.

Rationale for Recommendation
CalOptima must be responsive to changes in the health care marketplace, protecting existing investments by enhancing marketing activities to match the competitive market.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Previous Board Action dated April 4, 2019
2. PACE in Overlapping Service Area Report
3. Entities Covered by this Recommend Board Action

/s/ Richard Sanchez — *09/23/2020*
Authorized Signature — **Date**

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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

24. Consider Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Consider requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima.
2. If requests for letters of support are approved, authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to submit CalOptima letter(s) of support to the Department of Health Care Services.

Background

The Department of Health Care Services (DHCS) issued PACE policy letters regarding the PACE application process on October 27, 2017, and on August 17, 2018, that outline the process for an independent PACE facility to operate in County Organized Health System (COHS) counties including Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. California Welfare & Institutions Code section 14087.5 *et seq*. provides that when a COHS plan is established in a county, that COHS plan holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county.

However, the above-referenced DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in a COHS county if its application to DHCS includes a letter of support from the COHS Medi-Cal managed care plan. In the letter, the COHS plan must take the significant step of requesting that DHCS submit a formal request to the federal Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver as part of the independent PO application process to make an exemption to the existing law that governs COHS plans. COHS plans, including CalOptima, are under no obligation to provide such letters of support.

Specific to the application process for organizations seeking to operate in COHS counties, the COHS role is to issue (or not issue) a letter of support. If the COHS plan does not issue a letter of support, DHCS will not approve the application; if the COHS does provide a letter of support, it will be up to the state and federal regulators to make all subsequent decisions on the application.

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In response to the DHCS policy letters, on September 6, 2018 the Board approved a process to consider requests for letters of support from organizations seeking to establish PACE operations in Orange County independent of CalOptima. Elements of the process include, but are not limited to:

- Geographic ZIP code designation, consistent with the DHCS and CMS PACE organization application process and policy, independent PO letter of support requests will include the specific zip codes;
- Threshold Criteria (50% weighting), including PACE operating experience, financial soundness quality performance/metrics and demographic competence; and,
- Primary Criteria (50% weighting), including the potential impact on CalOptima PACE program/operations and independent POs operating in Orange County, if any.

Requests for letters of support were accepted from November 1, 2018 through January 31, 2019.

Discussion

CalOptima received requests for letters of support from two organizations, AltaMed Health Services (AltaMed) and Innovative Integrated Health, Inc. dba Fresno PACE (Fresno PACE). Both organizations submitted documentation for the requested elements.

Geographic ZIP code designation

AltaMed Health Services	Innovative Integrated Health, Inc. dba Fresno PACE
• PO seeks to operate in zip codes in Anaheim and Santa Ana • 48.7% of current CalOptima PACE participants reside in these cities • All requested zip codes overlap CalOptima service areas	• PO seeks to operate in one or more zip codes in 16 of the 34 cities in Orange County including: Anaheim, Brea, Buena Park, Cypress, Fullerton, Irvine, La Palma, Lake Forest, Los Alamitos, Midway City, Orange, Placentia, Stanton, Villa Park, Westminster, Yorba Linda • 47.1% of current CalOptima PACE participants reside in these cities. • All requested zip codes overlap CalOptima service areas

Threshold Criteria

Criteria	Response	
	AltaMed Health Services	Innovative Integrated Health, Inc. dba Fresno PACE
PACE operating experience	Information submitted; no areas of concern identified in the information submitted	Information submitted. PO will have five (5) years experience in November 2019
Financial Soundness	Information submitted; no areas of concern identified in the information submitted	Information submitted; no areas of concern identified in the information submitted.
Quality Performance/Metrics	PO outperformed CalPACE average performance for all criteria requested with the exception of readmission rate; note readmission rates are highly variable due to the small baseline population	PO outperformed CalPACE average performance for all criteria requested.
Demographic competence	Information submitted; no areas of concern identified in the information submitted	Information submitted; no areas of concern identified in the information submitted

Primary Criteria

In addition to the above, independent POs were required to provide information related to the potential impact on CalOptima PACE program/operations and independent POs operating in Orange County, if any.

AltaMed

AltaMed's request indicates an intention to focus on Anaheim and Santa Ana. These cities border Garden Grove, the primary service location for CalOptima PACE. Nearly 49% of CalOptima PACE enrollees are from the two proposed cities. AltaMed also indicated it would establish a particular focus on low-income Hispanic population. More than 50% of CalOptima PACE participants list Spanish as their primary language and approximately 80% of CalOptima PACE staff are bilingual, primarily Spanish speaking. Further, AltaMed's request notes that many of the participants in its existing PACE programs originate from referrals from primary care providers; it further specifically notes that AltaMed's Federally Qualified Health Clinics (FQHCs) in Anaheim and Santa Ana would serve as an "excellent built-in" referral system for an AltaMed PACE. Additionally, CalOptima PACE received regulatory approval to use community-based physicians to increase access and support continuity of care for PACE participants

Fresno PACE

Fresno PACE's request states that it has not chosen zip codes, especially in Garden Grove and Santa Ana, which represent a high percentage of CalOptima PACE. Approximately 47% of CalOptima PACE participants reside in the cities identified by Fresno PACE. Additionally, CalOptima PACE recently partnered with Sultan Adult Day Care in Anaheim, a contracted Community-Based Adult Services (CBAS) provider, as an Alternate Care Setting (ACS). Sultan Adult Day Care is a registered dba of Pacific GIS, Inc. Per Pacific GIS's licensing documentation at the California Department of Aging, several of its officers and directors are also officers and/or directors of Fresno PACE.

Potential Impact on CalOptima PACE

CalOptima staff has identified the following impact of adding independent POs in Orange County.

- Modification to COHS model: COHS plans hold the exclusive right to contract for Medi-Cal services in the county. If approved, CalOptima will need to specifically request that DHCS submit to the federal government a request to amend California's section 1115 Waiver to allow the independent operation of a specified PO in Orange County.

- No control over sites or service areas: There is no indication that DHCS would require a new letter of support if an approved independent PO later seeks to expand its service area. Thus, it is possible that these POs could request expansion beyond the current request without input from CalOptima.

- Increased administrative costs for CalOptima PACE: Both POs have expressed interest in central Orange County where a significant number of CalOptima PACE participants reside, which may require that CalOptima PACE make a greater investment into marketing. CalOptima PACE maintains a very low marketing budget. In the most recent National PACE Association National Benchmarking Report, CalOptima expended only $14.00 per member per month for marketing expenses compared to the national median of $43.50 per member per month.

Overall Summary

As proposed, independent POs would overlap with CalOptima PACE and raise the potential of adverse selection of membership served. While there currently is no "wait list" for qualifying individuals interested in participating in PACE in Orange County, independent POs in Orange County may bring greater awareness of the PACE program, and add choice and preference for mostly low-income seniors in Orange County.

Staff recommends that the Board consider whether to submit to DHCS a letter of support in response to the request of each organization seeking to offer PACE services in Orange County independent of CalOptima in accordance with regulatory guidance.

Fiscal Impact

In the event the Board approves the request(s) for letters of support from one or both POs and authorizes the CEO to submit such letter(s) to DHCS, the fiscal impact is unknown at this time. The addition of one or two PACE facilities operating in overlapping service areas with CalOptima's current PACE

program will likely have an adverse effect on current levels of enrollment, revenue, and income. Lower enrollment or decelerating enrollment growth would decrease revenues and increase unit cost, directly affecting administrative expenses as many PACE services rely on maximizing economies of scale. In addition, a reduction in net income will elongate the payback period for CalOptima's capital investments in the PACE program.

Rationale for Recommendation

Consistent with the October 27, 2017 and August 17, 2018 PACE Policy Letters, to determine whether or not the CalOptima Board will authorize CalOptima to submit to DHCS a Letter of Support in response to each organization's request in connection with such organization's interest in becoming an independent PACE Organization in Orange County.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 1, 2018, Consider Authorizing Contracts with Alternate Care Settings (ACS) to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly (PACE)
2. Board Action dated September 6, 2018, Consider Approval of Process for Considering Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Contracts with Alternative Care Settings (ACS) to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Enter into contracts with Community Based Adult Services (CBAS) centers to serve as Alternative Care Setting (ACS) sites for CalOptima PACE members; ~~and~~
2. Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs, subject to Board approval; and
3. Staff to report performance metrics back to the Board.

Rev. 2/1/2018

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE Center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. CalOptima opened its PACE center on October 1, 2013, and currently serves approximately 238 members at the single location.

At its February 4, 2016 meeting, the Board authorized submission of a service area expansion to the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), authorized a Request for Proposal (RFP) process for the ACS model for PACE expansion satellite locations to include CBAS centers, and directed staff to perform additional analysis. Subsequently, at its May 4, 2017 meeting, the Board requested that staff first issue a Request for Information (RFI) on alternative care settings. The RFI was released on May 26, 2017. Findings from the RFI, including a market analysis, locations and capabilities of potential ACS sites, were used to develop a RFP, which was released on November 3, 2017. Staff has completed scoring of the proposals and qualified five CBAS centers based on:

- CBAS center currently serving CalOptima members located in or adjacent to the service area
- Operational for a minimum of one year
- Capacity to provide services to a minimum of 15 CalOptima PACE members

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- Fiscal soundness, as evidenced by evaluation of financial statements for three consecutive years, as well as a third-party risk report when available. Metrics evaluated include liquidity, debt ratio, short-term viability, and delinquency.
- Capable of providing six of the seven PACE core services per PACE regulatory requirements and evaluated according to descriptions of the operational, security, financial, compliance and analytics requirements of the RFP.
- In good standing with regulatory agencies, as evidenced by no active corrective action plans or sanctions.
- Capacity to increase access to services based on cultural competency, geographical area or medical condition.

The five CBAS centers that qualified through the RFP process are listed in Attachment 1.

While CalOptima's current service area is limited to north Orange County, the ACS model is expected to be an important step toward increasing access to PACE services throughout Orange County. CalOptima's request for expansion of the service area to include all Orange County Zip Codes is currently under review by CMS, with approval anticipated as soon as July 1, 2018. Four of the five CBAS centers qualified through the RFP are in the current service area, with one in the proposed expanded service area.

Discussion

Using alternative care settings for CalOptima PACE members is expected to increase access to culturally and linguistically competent, specialized services in close geographical proximity to participants' residences. CMS defines an alternative care setting as a facility, other than the participants' primary residence, where PACE participants receive the services listed in section 460.98 of U.S. Code: Title 42 (Public Health and Welfare).

In accordance with section 460.98, an ACS can provide six of the seven core PACE services, with the seventh, primary care, provided by the CalOptima PACE site. ACS sites will provide the following six services:

- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals

Interdisciplinary Team assessment and care planning will remain components provided directly by the PACE center. Primary care may be provided by CalOptima PACE or a community-based physician, on an individualized basis. Transportation services will be provided by CalOptima PACE or by ACS sites, based on the ability to fulfill operational and quality standards. The proposed contracts include rates and terms for ACS sites deemed capable of providing transportation services.

Through the RFP process, staff have developed a program design for CalOptima PACE to utilize ACS, including operational and quality standards required to be designated as an ACS. In the future, ACS sites may potentially be added based on a tool that determines operational and quality standards required to operate as an ACS, allowing CalOptima PACE to respond to access needs in specific areas of the county.

Fiscal Impact

The recommended actions to authorize contracts with CBAS centers to serve as PACE ACS sites are expected to increase enrollment in the PACE program, while maintaining current financial performance. Pro forma projections for Fiscal Year 2018-19 assume a net increase of two members per month related to the addition of the ACS sites. Increasing access to PACE services through the ACS strategy is expected to allow more eligible county residents to participate in the CalOptima PACE program, and may improve operational efficiencies and increase economies of scale. CalOptima will pay contracted ACS sites a per diem rate derived from CalOptima PACE's experience and projected unit costs for day center attendance, which includes six of the seven core PACE services. Given the modest anticipated enrollment increase, Management projects that the medical loss ratio, administrative loss ratio, and net margin will remain consistent with current levels through the fiscal year.

Rationale for Recommendation

Alternative care settings will increase access to care for current PACE members. Specifically, these services are culturally competent and specialized, possibly in more convenient geographical locations to PACE members' residences. In addition, the alternative care setting strategy has been identified as a vehicle for expanding the PACE model of care to all Zip Codes of Orange County. Currently, service area is limited to 60-minute one-way ride radius from the PACE center in Garden Grove. With ACS 'satellite' sites throughout Orange County, eligible CalOptima members will have access to the coordinated quality care provided by CalOptima PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. RFP-Qualified CBAS Providers
2. PowerPoint Presentation: PACE Alternative Care Setting (ACS) RFP Results

/s/ Michael Schrader *1/25/2018*

Authorized Signature **Date**

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RFP-Qualified CBAS Providers

Center Name	Contract Name	Contract Effective Date	Center Address
Acacia Adult Day Services	Acacia Adult Day Services	7/1/12	11391 Acacia Parkway Garden Grove, CA 92840
Anaheim VIP Adult Day Health Care	Community Seniorserv, Inc., dba Anaheim VIP Adult Day Health Care	7/1/12	1158 North Knollwood Circle Anaheim, CA 92801
Santa Ana/Tustin VIP Adult Day Health Care	Community Seniorserv, Inc., dba Santa Ana/Tustin VIP Adult Day Health Care	7/1/12	1101 South Grand Avenue, Suite L Santa Ana, CA 92705
South County Adult Day Services	Alzheimer's Orange County	7/1/12	24260 El Toro Road Laguna Woods, CA 92637
Sultan Adult Day Health Care Center	Pacific GIS, Inc., dba Sultan Adult Day Health Care Center	7/1/12	125 W. Cerritos Avenue Anaheim, CA 92805

PACE

CalOptima

A Public Agency

Better. Together.

PACE Alternative Care Setting (ACS) RFP Results

Board of Directors Meeting

February 1, 2018

Richard Helmer, M.D., Chief Medical Officer

Elizabeth Lee, Director, PACE

Goal of Implementing ACS

- To expand access to PACE to all eligible Orange County seniors
  - Geographic coverage in current North County service area and future South County service area, anticipated in July 2018

- To ensure PACE supports participants' unique needs
  - Culture competence
  - Language access
  - Health conditions

ACS Background

- Staff progress on Board-approved ACS directives
  - September 2016: Presented financial information to Finance and Audit Committee (FAC)
  - February 2017: Updated FAC with additional financial performance metrics
  - May 2017: Conducted a three-hour PACE Study Session for the full Board, with a presentation by the state regulator and analysis of ACS by National PACE Association
  - May 2017: Issued a Request for Information (RFI) from potential ACS partners
  - August 2017: Distributed a 300-page PACE informational binder to the Board
  - November 2017: Released a Request for Proposal (RFP) for ACS partners

PACE and CBAS Alignment

- PACE and Community-Based Adult Services (CBAS) centers serve similar populations
  - Are nursing home-eligible
  - Have multiple chronic conditions
  - Need help with activities of daily living
- PACE and CBAS centers have an opportunity to better meet participants' preferences and needs
  - Increased convenience and appropriateness for participants
    - Conditions, language and ethnicity, and residence
- PACE and CBAS centers seeking new avenues for growth
  - CBAS centers are a referral source to PACE
  - Partnership provides CBAS centers with stable revenue

CBAS as an ACS

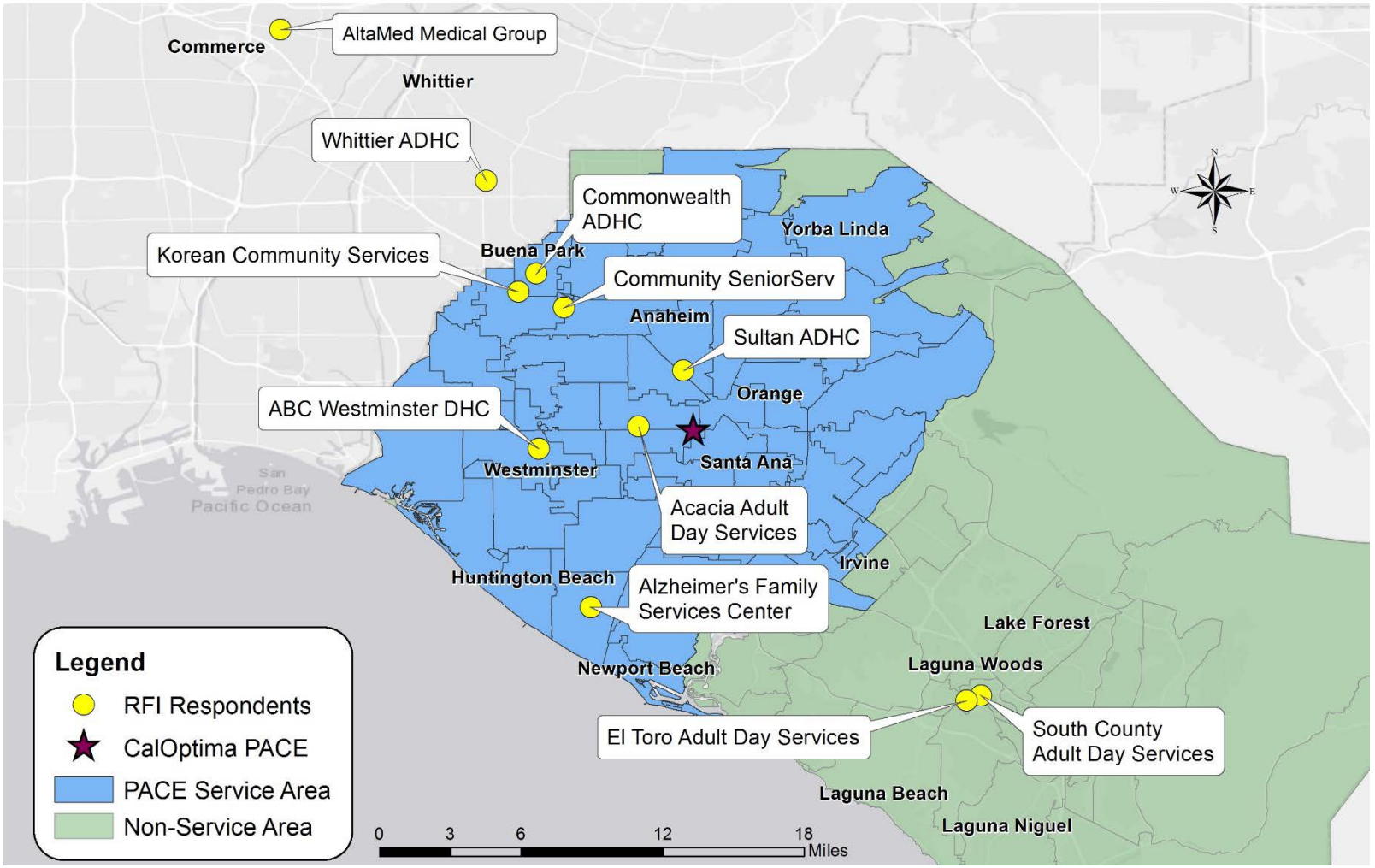
- CBAS centers deliver six of seven core PACE services
  - Social services
  - Restorative therapies
  - Personal care and supportive services
  - Nutritional counseling
  - Recreational therapy
  - Meals

- CalOptima PACE retains responsibility for the seventh core service
  - Primary care

RFI Background

- CalOptima issued an RFI for ACS sites in May 2017
- Responses were collected, with all Orange County respondents interviewed as of August 2017
- There were a total of 11 respondents, nine located in Orange County
  - Of those nine, eight were licensed CBAS centers

RFI Respondents/PACE Service Area



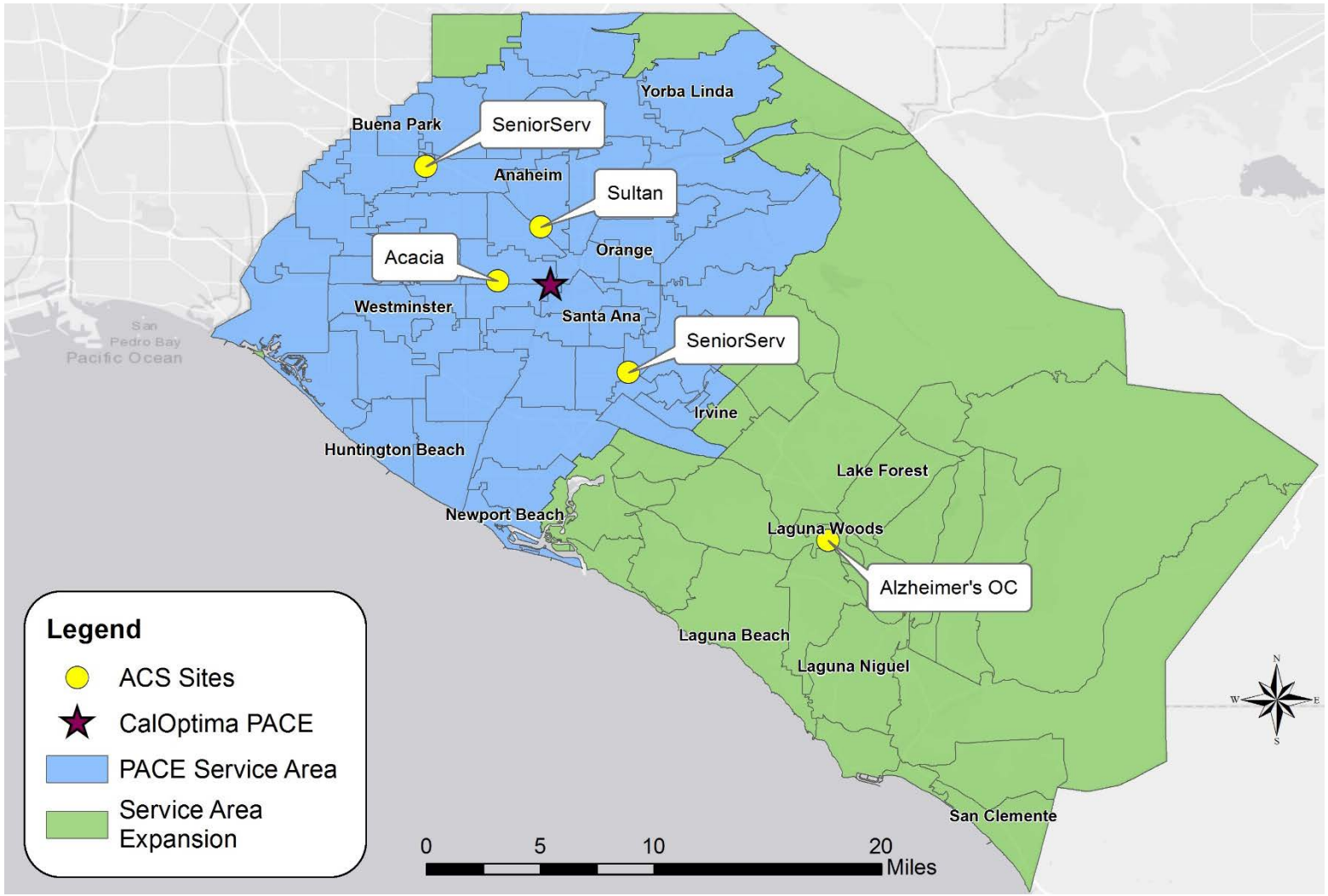
RFI Findings

- Interest level provided a solid basis from which to move forward on a countywide RFP
- Respondents seemed to understand the ACS concept and have elements in place to participate
- Information from respondents helped the development of a program design, including operational, quality and capacity standards, for the RFP

RFP Background

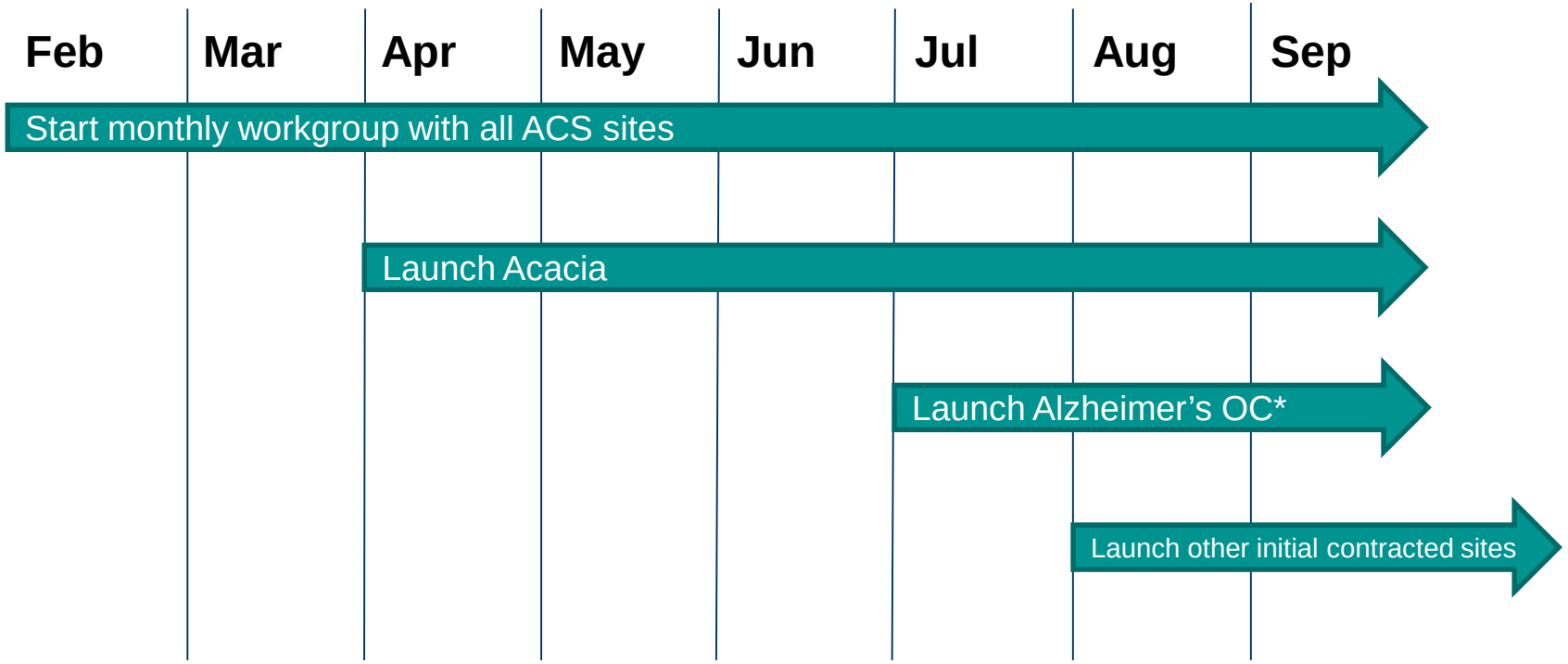
- CalOptima issued an RFP for ACS sites in November 2017
  - RFP included detailed criteria
    - Operational
    - Security
    - Financial
    - Compliance
    - Analytics
  - RFP included a proposed contract amendment, which defined rates and requirements
- There were eight respondents
- Site visits were conducted with respondents meeting the initial criteria
- Five respondents were deemed qualified

Proposed ACS Sites



Phased Implementation

- Phased implementation supports use of best practices
- Monthly workgroup fosters collaboration from the start



** Pending CMS approval of service area expansion*

Additional ACS Sites

- Program design allows for additional ACS sites to be added based on an application process that:
  - Assesses operational and quality standards
  - Considers potential PACE participant needs
  - Supports efficient use of time and resources
  - Accommodates future growth

Staff Recommendation

- Authorize the Chief Executive Officer, with the assistance of legal counsel, to:

  - Enter into contracts with CBAS centers to serve as ACS sites for CalOptima PACE members, and;

  - Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Approval of Process for Considering Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Action

Authorize the CEO to implement a process to consider requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima, with all final decisions subject to Board approval.

Background

PACE is a comprehensive health care program that CalOptima provides for frail seniors in Orange County. The PACE model is a person-centered, community-based alternative to nursing home care. PACE supports elders and their families by providing preventive and primary care, and coordinating behavioral health and acute care, as well as long-term services and supports. The intensive care coordination helps individuals with complex chronic care needs to continue living in the community as long as possible. CalOptima opened Orange County's first PACE center in October 2013, and the program has grown to nearly 300 participants. CalOptima recently launched several new initiatives designed to expand access to PACE, including partnerships with Community-Based Adult Services (CBAS) centers, a greater role for community-based physicians in caring for PACE participants, and a larger PACE service area to reach all eligible seniors in Orange County.

On October 27, 2017, and on August 17, 2018, the Department of Health Care Services (DHCS) issued PACE policy letters regarding the PACE application process, including guidance on operation of an independent PACE facility in County Organized Health System (COHS) counties including Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. Welfare & Institutions code section 14087.5 *et seq*. provides that a managed care plan that elects to organize as a COHS holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county.

However, the above-referenced DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in a COHS county if its application to DHCS includes a letter of support from the COHS Medi-Cal managed care plan. In the letter, the COHS plan must take the significant step of requesting that DHCS submit a formal request to the federal Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver as part of the independent PO application process to make an exception to the existing

law that governs COHS plans. COHS plans, including CalOptima, are under no obligation to provide such letters of support.

Specific to the application process for organizations seeking to operate in COHS counties, the COHS plans' only role is to issue (or not issue) a letter of support. If the COHS plan does not issue a letter of support, DHCS will not approve the application; if the COHS does provide a letter of support, it will be up to state and federal regulators to make all subsequent decisions on the application.

Since the release of the DHCS policy letters, staff has received informal inquiries from groups interested in applying to become independent POs in Orange County on how and whether CalOptima intends to respond to any requests for letters of support requesting that DHCS seek formal modification of California law governing the COHS framework.

Should CalOptima decide to provide one or more letters of support to independent POs, the decision would then be out of CalOptima's hands, and the independent POs would follow an application process first involving DHCS, and if DHCS submits the request, CMS would consider whether to approve the requested waiver amendment. If CMS approves the waiver amendment, DHCS would then evaluate the independent PO application, and if approved, the application would go to CMS for final approval.

Separate from considering requests from independent POs, CalOptima staff is continuing Board-approved expansion efforts through collaboration with community partners. These include expanding CBAS center use through Alternative Care Setting sites, continuing to cultivate referrals from contracted community-based physicians, enrollment efforts in South Orange County, increasing current sales and marketing efforts, adding a Veteran's Choice option to encourage enrollment by veterans, and adding a Medicare-only members option.

Discussion

In response to the DHCS policy letters and independent PO inquiries, staff is recommending that the Board approve an internal review process for the evaluation of requests for letters of support from organizations seeking to establish independent PACE operations in Orange County and making recommendations to the Board.

Elements of the process to consider letter of support requests include, but are not limited to:

1. **Application timeline window:** Subject to Board approval, staff anticipates accepting letters of support requests beginning November 1, 2018, to January 31, 2019.
2. **Geographic ZIP code designation:** Consistent with the DHCS and CMS PACE organization application process and policy, independent PO letter of support requests will include the specific ZIP codes the independent PO is interested in serving.
3. **Threshold Criteria (~~20~~50% weighting):** All letter of support requests from independent POs shall include and will be evaluated based on the following criteria:
    a. PACE operating experience
        i. Show a minimum of five (5) years of operating experience
        ii. Provide proof of regulatory audits with no sanctions

Rev. 9/6/18

iii. Submit operational policies and procedures
iv. Obtain reference letters from member advocates, providers and community stakeholders

b. Financial soundness
   i. Submit financial statements (income statements and balance sheets) for the three most recent consecutive years
   ii. Report financial metrics (i.e. liquidity, debt ratio, short-term viability, delinquency)
   iii. Obtain third-party risk report via Dunn and Bradstreet (where available)

c. Quality performance/metrics
   i. Report performance against current CalPACE averages in areas of participants residing in nursing homes, hospital admissions, hospital days, hospital readmission rate, emergency room visits and participant satisfaction rating

d. Demographic competence
   i. Provide a general PACE demographic profile data of the ZIP code area of interest
   ii. Demonstrate staff experience and/or understanding in serving PACE participants similar to those in the potential geographic area
      1. Training in cultural competency
      2. Language capability
      3. Accommodations for low literacy
      4. Response to socioeconomic factors

4. **Primary Criteria (~~80~~ 50% weighting):** Potential impact on CalOptima PACE program/operations and other POs operating in Orange County, if any. Rev. 9/6/18
   a. For POs with strong demonstrated performance on the Threshold Criteria, the focus would be on, for example, evaluation overlap with existing PACE facilities in the County (e.g., also considering likelihood of adverse member selection, geographic separation, etc.); how the PO's application demonstrates that they are proposing to offer complementary PACE services (e.g., for unique member populations, serving remote/underserved geographic areas of the County, bringing new providers, or in some other meaningful ways, enhancing existing PACE facilities).

5. **Return to the Board with Recommendations**. After analyzing PO proposals and requests for letters of support, staff will return to the Board with recommendations.

Fiscal Impact

The recommended action is projected to be budget neutral. CalOptima's Fiscal Year 2018–19 Operating Budget, approved by the Board on June 7, 2018, included projected revenues and expenses related to the continuation of PACE expansion.

Staff anticipates that the administrative expenses included in the Board-approved operating budget are sufficient to cover the anticipated costs related to the recommended action.

Rationale for Recommendation

Staff recommends that the Board adopt a process for considering requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima. As a public agency, CalOptima should be prepared to respond to such potential requests.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS PACE Policy Letter 17-03, issued on October 27, 2017.
2. DHCS PACE Policy Letter 18-01, issued on August 17, 2018.
3. Presentation: PACE Response to Regulatory Guidance

/s/ Michael Schrader — **Authorized Signature**

8/29/2018 — **Date**

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date: October 27, 2017

Policy Letter 17-03
Replacing PACE Policy Letter 16-01

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the revised Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of POs that could operate in the state, and allowed for-profit entities to become POs. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.

The Centers for Medicare & Medicaid Services (CMS) released the 2017 PACE Application Guidance on January 17, 2017, to address its electronic PACE application submission timelines and review process. Effective immediately, all new and expansion PACE applications are required to be submitted to CMS through the web-based Health Plan Management System (HPMS). Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.

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Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

Action	**Due Date**	**Documents for Submission**	**Reviewer**	**Review Timeframe**
Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	• Letter of Intent • Letter for Support from COHS (if applicable)	DHCS	N/A
Initial Application Submission to DHCS	60 days prior to CMS application submission deadline	• Market Feasibility Study • Letters of Support • Application sections (see Attachment 1)	DHCS	60 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	• Remaining application sections • State Assurance Page	DHCS/CMS	Align with CMS 45/90 day review clock

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received, (Initial Application or Service Area Expansion).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS.It is also during this period that DHCS conducts the Readiness Review (RR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a RR of

the new center. All deficiencies that may be identified during the DHCS Readiness Review onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

New PACE Organization – New entity applying to establish a PO

- Entity must identify specific zip codes to be served in one or more counties
- Entity must be able to serve all requested zip codes from PACE Center (subject to 60-minute one way travel time adult day health center (ADHC) requirement)
- Rate development required for each county requested

Existing PO Expansion (Existing County) – PO adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) (subject to 60-minute one way travel time ADHC requirement)
- POs can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization
- Zip code only expansions subject to shorter State/CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Key Dates for CMS Application Submission

The downloadable PDF of the application and additional information such as application submission deadlines can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Downloads/PACE_Application_Training_Feb_2017.pdf.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant's PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx. Pending applications for new or expansion POs will also be posted to the DHCS website.

Based on the CMS application submission deadlines, LOI to DHCS would follow the below timeframes:

Letter of Intent to DHCS no later than…	**Initial Application Submission to DHCS no later than…**	**CMS Application Submission Deadlines *last business day of Quarter**
October 1, 2017	November 1, 2017	January 1, 2018
January 1, 2018	February 1, 2018	April 1, 2018
April 1, 2018	May 1, 2018	July 1, 2018
July 1, 2018	August 1, 2018	October 1, 2018

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership

- Identify all competitive factors impacting the market, such as:
    - Existing POs
    - Managed care plans (MCPs)
    - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
    - Medi-Cal Waiver Programs
    - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
    - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as “grandfathered” in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department’s prior written approval.

Please note that DHCS’ prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant’s home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a

third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan,

notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

Jacey Cooper, Acting Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X		X	
Governing Body	3.3	X		X	
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X		X	
Grievance	3.7	X		X	
Appeals	3.8	X		X	
Enrollment	3.9	X		X	
Disenrollment	3.10	X		X	
Personnel Compliance	3.11	X			
Program Integrity	3.12	X			
Contracted Services	3.13	X	X		
Required Services	3.14	X			
Service Delivery	3.15	X			
Infection Control	3.16	X			
Interdisciplinary Team	3.17	X			
Participant Assessment	3.18	X			
Plan of Care	3.19	X			
Restraints	3.20	X			
Physical Environment	3.21	X			
Emergency and Disaster Preparedness	3.22	X			
Transportation Services	3.23	X	X		
Dietary Services	3.24	X			
Termination	3.25	X		X	
Maintenance of Records & Reporting	3.26	X			
Medical Records	3.27	X			
Quality Assessment Performance Improvement	3.28	X		X	
State Attestations	3.29	X		X	X
Waivers	3.30	X		X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over $5M in the past year
		Facility investment over $5M between 1 and 2 years
		Facility investment over $5M between 2 and 3 years
		No facility investments over $5M in last 3 years
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date: August 17, 2018

Policy Letter 18-01
Supersedes PACE Policy Letter 17-03

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the updated Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

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The Centers for Medicare & Medicaid Services (CMS) releases annual updates to its PACE Application Guidance to address its electronic PACE application submission timelines, requirements, and review process. Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at:
https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

State Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is

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necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.
Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

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Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	• Remaining application sections • State Assurance Page	DHCS/CMS	Align with CMS 45/90 day review clock

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received, (Initial Application or Service Area Expansion).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS. It is also during this period that DHCS conducts the Readiness Review (RR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a RR of the new center. All deficiencies that may be identified during the DHCS Readiness Review onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

New PACE Organization – New entity applying to establish a PO

- Entity must identify specific zip codes to be served in one or more counties
- Entity must be able to serve all requested zip codes from PACE Center (subject to 60-minute one way travel time adult day health center (ADHC) requirement)
- Rate development required for each county requested

Existing PO Expansion (Existing County) – PO adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) (subject to 60-minute one way travel time ADHC requirement)
- POs can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization
- Zip code only expansions subject to shorter CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant's PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx. Pending applications for new or expansion POs will also be posted to the DHCS website.

CMS application submission deadlines can be found under the application training guide here: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html. The LOI to DHCS must be submitted at least 90 days prior to the proposed CMS submission date and the initial application must be submitted at least 60 days prior to the proposed CMS submission date.

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-

Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership
- Identify all competitive factors impacting the market, such as:
    - Existing POs
    - Managed care plans (MCPs)
    - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
    - Medi-Cal Waiver Programs
    - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
    - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

State Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as "grandfathered" in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department's prior written approval.

Please note that DHCS' prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant's home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan, notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition. Replacement Centers are not subject to the January 1 or July 1 start dates.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

ORIGINAL SIGNED BY

Sarah Eberhardt-Rios, Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X	X	X	X
Governing Body	3.3	X	X	X	X
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X	X	X	X
Grievance	3.7	X	X	X	X
Appeals	3.8	X	X	X	X
Enrollment	3.9	X	X	X	X
Disenrollment	3.10	X	X	X	X
Personnel Compliance	3.11	X	X		
Program Integrity	3.12	X	X		
Contracted Services	3.13	X	X		
Required Services	3.14	X	X		
Service Delivery	3.15	X	X		
Infection Control	3.16	X	X		
Interdisciplinary Team	3.17	X	X		
Participant Assessment	3.18	X	X		
Plan of Care	3.19	X	X		
Restraints	3.20	X	X		
Physical Environment	3.21	X	X		
Emergency and Disaster	3.22	X	X		
Transportation Services	3.23	X	X		
Dietary Services	3.24	X	X		
Termination	3.25	X	X	X	X
Maintenance of Records &	3.26	X	X		
Medical Records	3.27	X	X		
Quality Assessment Performance Improvement	3.28	X	X	X	X
State Attestations	3.29	X	X	X	X
Waivers	3.30	X	X	X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

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Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over $5M in the past year
		Facility investment over $5M between 1 and 2 years
		Facility investment over $5M between 2 and 3 years
		No facility investments over $5M in last 3 years
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area

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PACE

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PACE Response to Regulatory Guidance

Board of Directors Meeting

September 6, 2018

Phil Tsunoda, Executive Director, Public Policy and Public Affairs

Current PACE Landscape

- Alternative and new methods of expansion are in line with the national PACE growth initiative, known as PACE 2.0

- CalOptima PACE has a variety of expansion strategies in place
  - Alternative Care Settings
  - Community-based physicians
  - Service area expansion to south Orange County

- DHCS Policy Letters create an opportunity for independent PACE centers to operate in County Organized Health System (COHS) counties

DHCS Policy Letters

- October 2017 and August 2018 letters outline the policies affecting the application review process and timelines, as well as restrictions on delegation

- Of note to CalOptima, the policy letters require a letter of support from the COHS health plan as part of an independent PACE Organization (PO) application

DHCS Policy Letters (Cont.)

"DHCS will only consider the operation of an independent PO in a COHS county if the applicant includes a letter of support from the COHS stating:

- The COHS' support for the establishment of the independent PO in the county
- The COHS' request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county"

Regulatory Approval

- CalOptima's *only role* with regard to an independent PO applying to operate in a COHS county is *at the beginning*, in considering whether to issue a letter of support and associated 1115 Waiver amendment request
- Lengthy application process follows this sequence:
  1) Independent PO requests from COHS a letter of support, which includes the 1115 Waiver amendment request
  2) If letter of support is provided, independent PO submits to DHCS a letter stating its intent to apply to operate a PACE center
  3) DHCS considers whether to submit to CMS the waiver amendment request
  4) If DHCS submits, CMS considers whether to approve the waiver amendment request
  5) If CMS approves the waiver amendment, DHCS evaluates the independent PO application
  6) If DHCS approves the application, CMS evaluates the independent PO application

Process for Consideration of Letter of Support

- CalOptima proposes a fair and objective evaluation process that includes, but is not limited to, certain elements:

- Application timeline window
  - Independent POs may submit letter of support requests during the period of November 1, 2018, to January 31, 2019

- Geographic ZIP code designation
  - Independent POs must include the specific ZIP codes the PO is interested in serving within Orange County

Process for Consideration of Letter of Support (Cont.)

- Threshold Criteria (20%)
  1. Operating experience
  2. Financial soundness
  3. Quality performance
  4. Demographic competence

- Primary Criteria (80%)
  5. Potential impact to CalOptima PACE program

Criterion 1: Operating Experience

- Show a minimum of five years of experience operating a PACE center
- Provide evidence of regulatory audits with no sanctions
- Submit operational policies and procedures
- Obtain reference letters from member advocates, providers and community stakeholders

Criterion 2: Financial Soundness

- Submit financial statements for the three most recent consecutive years
  - Income statements
  - Balance sheets
- Report important financial metrics
  - Liquidity
  - Debt ratio
  - Short-term viability
  - Delinquency
- Obtain third-party risk report via Dunn and Bradstreet where available

Criterion 3: Quality Performance

- Report performance against current CalPACE averages
  - Participants residing in nursing homes
  - Hospital admissions per 1,000
  - Hospital days per 1,000
  - Hospital readmission rate
  - Emergency room visits per 1,000
  - Participant satisfaction rating

Criterion 4: Demographic Competence

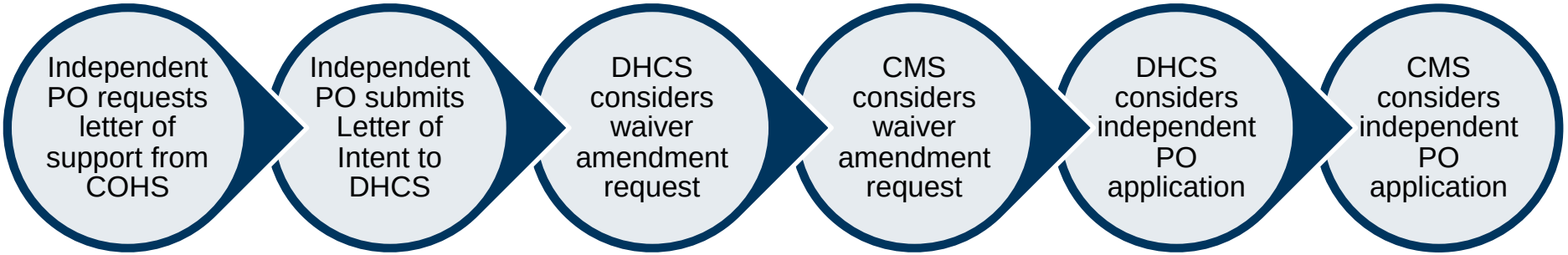
- Provide a general PACE demographic profile of the ZIP code area of interest

- Demonstrate staff experience/understanding in serving PACE participants similar to the potential participants in the geographic area of interest
  - Training in cultural competency
  - Language diversity and capability
  - Accommodations for low literacy
  - Response to socioeconomic factors

Criterion 5: Impact to CalOptima PACE

- State potential impacts of an independent PO on CalOptima's existing PACE program

PACE Application Process



If the application is approved, the independent PO would contract directly with DHCS and CMS

Recommended Actions

- Approve CalOptima PACE expansion strategy in response to state regulatory guidance.

- Authorize the CEO to implement a process to consider letters of support for qualified organizations seeing to establish an independent PACE facility in Orange County.
  - Staff to bring back for Board approval any recommendation regarding a letter of support for an independent PO letter.

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Enhance PACE Marketing Campaign in a Competitive Service Area

October 1, 2020

Elizabeth Lee, Director, PACE Program

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CalOptima's PACE Program

- Exemplary Outcomes*
  - < 1% of participants reside in long-term care
  - 95% pneumococcal vaccination rate
  - 97% influenza vaccination rate
- State and National Recognition
  - #1 participant satisfaction rating among PACE organizations in California
  - Recognition from the National PACE Association as a "shooting star" and "supernova" for growth and access to PACE
- Steward of Public Funds**
  - Revenue: $42,189,583
  - Medical Costs: $37,731,523 (89.4% ALR)
  - Administrative Costs: $2,002,647 (4.7% MLR)
  - Net Operating Margin: $2,455,414

* PACE 2019 Quality Improvement Plan Evaluation

** Board approved FY 20–21 PACE Operating Budget

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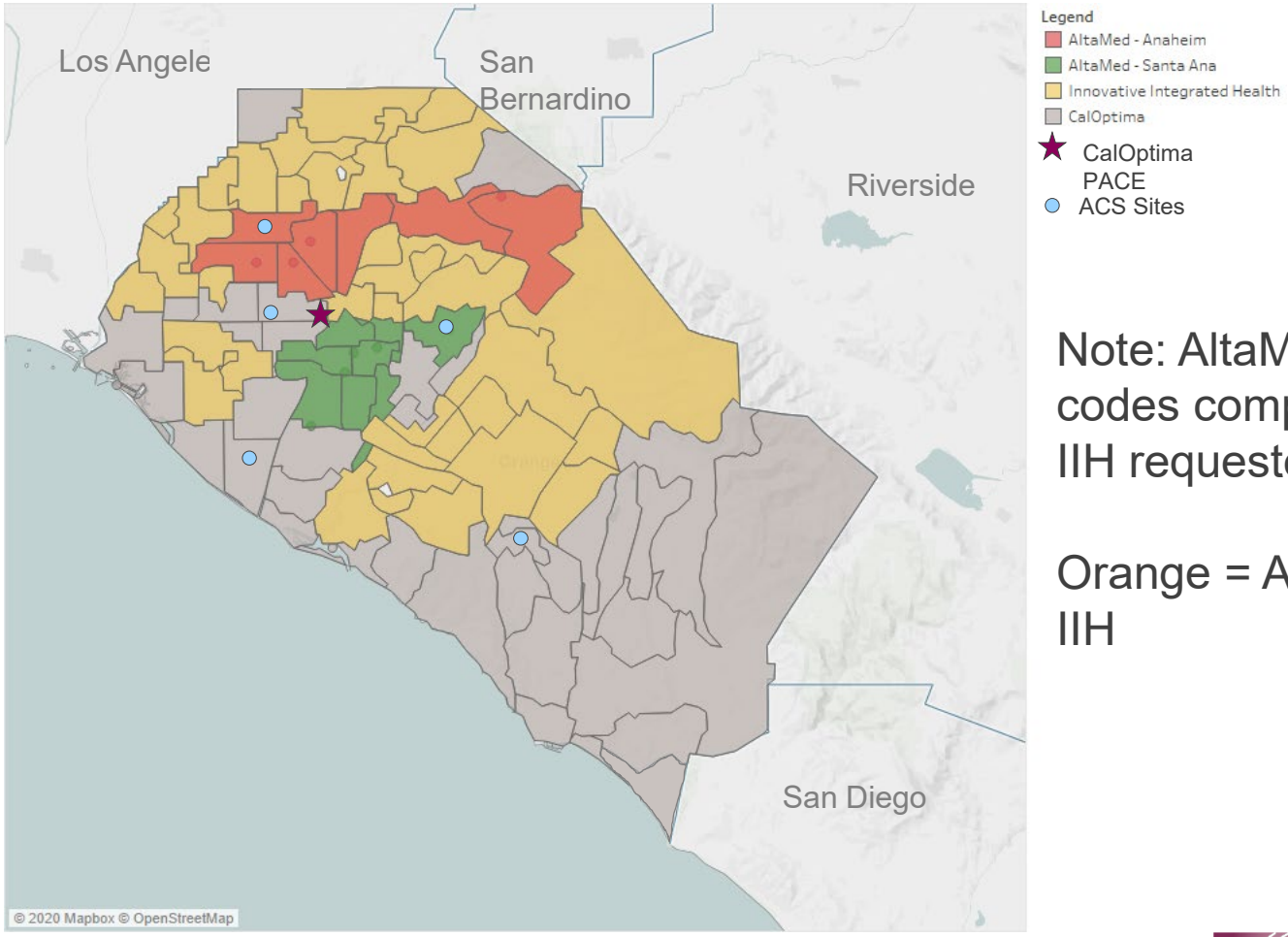
Background

- April 2019
  - CalOptima Board of Directors approved two letters supporting the establishment of independent PACE organizations in Orange County
- August 2020
  - DHCS notified CalOptima that CMS approved California's request to amend its Medi-Cal 2020 Section 1115(a) Demonstration Waiver to expand PACE in Orange County
    - AltaMed Health Services application to operate a PACE organization in Orange County was accepted
    - Innovative Integrated Health (IIH) submitted an application to operate PACE in Orange County with no timeline known publicly
  - January 2021
    - Anticipated opening of AltaMed Anaheim PACE site

Overlapping Service Area Map



Note: AltaMed Anaheim ZIP codes completely overlap with IIH requested service area

Orange = AltaMed Anaheim + IIH

Source: CalOptima PACE

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Service Area Overlap Analysis

- All 24 ZIP codes included in the AltaMed application and 44 ZIP codes in the IIH application overlap CalOptima's PACE service area.
- National PACE Association projections, based on US Census Data in 2019, estimated the total number of individuals in Orange County who are potentially eligible to enroll in PACE is approximately 6,000.
- Staff recommends elevation of CalOptima PACE brand through increased advertising and direct mail campaign activities to match our market.

Enhanced Marketing and Brand Awareness Campaign

Account	FY 21 Approved Budget	FY21 Enhanced Campaign Recommendation	Justification
Public Activities	$13,000	$8,000	Promotional items to support branding (outreach and retention); Senior Health and Wellness events
Member Communication	$140,000	$45,000	Direct mail, marketing materials, collateral
Advertising	$210,000	$175,000	Print, radio, outdoor, digital and television
	$363,000	**$228,000**	**Total for current budget and enhanced campaign $591,000**

Staff Recommendation

- Authorize unbudgeted expenditures in an amount up to $228,000 from existing reserves to support an enhanced marketing campaign for the remaining months in fiscal year 2020–21

Our Mission

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

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kenny the Printer	17931 Sky Park Circle	Irvine	CA	92714
Integrated Impressions	23232 Peralta Dr., Ste. 212	Laguna Hill	CA	92653
Vail Dunlap	9371 Irvine Blvd.	Irvine	CA	92618
Sapphire	PO Box 29338	Phoenix	Az	85038
The Dot	2424 McGaw Ave.	Irvine	CA	92614
Image Source	Image Source	Kirkland	WA	98034
Excelsior (OC Register)	PO Box 55210	Colorado Springs	CA	80962
Nguoi Viet (newspaper)	14891 Moran Street	Westminster	CA	92683
Vien Dong (newspaper)	14891 Moran Street	Westminster	CA	92683
Viet Bao (newspaper)	3941 Capri Ave.	Irvine	CA	92606
Seeb Magazine	5250 E. Honeywood Lane	Anaheim	CA	92807
Estrella Media (La Ranchera Radio, Estrella TV)	3101 W 5th Street	Santa Ana	CA	92703
Clear Channel	19320 Harborgate Way	Torrance	CA	90501
Outfront Media	PO Box 33074	Newark	NJ	07188
Spectrum Reach Cable Television	6 Hutton Center, Suite 150	Santa Ana	CA	92707

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contacts
Silver Ho, Executive Director, Compliance, (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 an Amendment(s) to the Primary Agreement between the California Department of Health Care Services (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 ensure that assigned members have access to covered, medically necessary health care services.

Discussion
DHCS has informed Plans, including CalOptima, that it will submit an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate rate changes related to Base Medi-Cal Classic rates, ACA Optional Expansion (OE) rates, Coordinated Care Initiative (CCI) Non-Full Dual rates, Hyde (Abortion), Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments for the period of July 2019 to December 2020 and Calendar Year (CY) 2019 Coordinated Care Initiative (CCI) Full Dual Rate Ranges to managed care plan (MCP) contracts. Capitation rates for managed care plans (MCPs), including CalOptima, are typically rebased annually. However, DHCS has implemented a onetime 18-month rating period for the period of July 1, 2019 through December 31, 2020 (Bridge Period), to aid in future prospective rate development as federally required. Rates will be developed and rebased annually on a calendar year (CY) basis thereafter.

Rate Changes

DHCS' proposed amendment(s) seeks to incorporate rates related to:

- Base Medi-Cal Classic, ACA Optional Expansion (OE) and Hyde (Abortion) Proposition 56 rates for the period of July 2019 to December 2020, with Behavioral Health Treatment (BHT)

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and Hepatitis–C supplemental payments, Hyde (Abortion) rates, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments.

Package XX: 2019–2020 Rates

Base Classic Medi–Cal and ACA Optional Expansion Rates

Noteworthy items for the updated rates for July 2019 to December 2020 include, but are not limited to:

- Ground Emergency Medical Transport (GEMT)
- Optional Benefits (e.g. Vision, Podiatry, Speech Therapy)
- Proposition 56 Payments
- Pass-Through Payments
- Hospital Directed Payments
- MCO Tax
- Health Homes Program (HHP)

The base Medi–Cal Classic and ACA OE capitation rates for July 2019 through December 2020 were first sent to CalOptima as draft rates in May 2019. DHCS sent CalOptima updated draft rates in June 2019, September 2019, November 2019, March 2020 and final rates in July 2020. The rates include CalOptima-specific rates prior to application of risk-adjustment for all 18 months of the bridge period and county averages, blended rates, and add-on details for the 12–month period of July 2019–June 2020.

Additionally, the rates reflect a rate rebase that utilizes CY 2017 experience, including Plan-submitted Rate Development Templates (RDTs) and encounter data. CalOptima's Capitation Rate Calculation Sheets (CRCS) display the category of service detail on the development of the rates from the finalized base data through to the gross medical expense, accounting for trend, policy changes, and managed care/efficiency adjustments.

Updates include the following base data adjustments:

- Updated rate summary structure to account for different effective dates on a number of rate components beginning with splitting the add-on details into the following three 6-month time periods:
    - July 2019 – December 2019
        - Prop 56 rate add-ons
        - Hospital Quality Assurance Fee (HQAF)
    - January 2020 – June 2020
        - MCO Tax
        - Prop 56 rate add-ns
        - HQAF
    - July 2020 – December 2020
        - MCO Tax
        - Prop 56 rate add-ons
        - HQAF

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- Updated risk adjustment for July 2020- December 2020 including budget neutral risk scores having been calculated utilizing July 2020- December 2020 enrollment projections.
- Updated MCO tax which includes the following:
    - Per CMS approval, the MCO tax applicable to the Bridge Period includes six months of SFY 19-20 budget year (January 1, 2020 – June 30, 2020) and six months of the SFY 20-21 budget year (July 1, 2020- December 31, 2020).
    - The projected enrollment used to calculate the MCO tax leveraged updated estimates that incorporates assumptions related to the emergency period for COVID-19 as well as the most recent enrollment (March 2020) available at the time of rate development.
- Updated HQAF pass-through payment to reflect a more current enrollment projection for July 2019 through December 2020.
- Inclusion of a 1.5% exhibit reflecting the difference and percent change between the certified rate and final payment rate, after applying the Gross Medical Expense (GME) 1.5% reduction, for the three 6-month periods of the Bridge Period.
    - The final certified payment rates are consistent with the current scenario of add-on PMPMs.
    - The PMPM used to reduce rates is specific to each health plan/county/Category of Aid (COA) combination, for Child, Adult, Affordable Care Act (ACA) Optional Expansion (AE) and Seniors and Persons with Disabilities (SPD).
    - The reduction PMPM is calculated as 1.5% of a lower bound GME rate calculated utilizing the aggregate lower bound administration and underwriting gain loads.
    - The aggregate percentage is Plan-specific based on a member weighted percentage of the COA-specific administrative and underwriting gain levels of the COHS plans.
        - The PMPM reduction is the same for lower bound, midpoint and upper bound.
    - The exhibit also displays the reduction applied to the blended rate range before add-ons and the final rate range.
- Hepatitis C drugs have been excluded from the base data as they are included within the Hepatitis C supplemental payment process.
- Removal of Managed Long-Term Support Services (MLTSS) related costs such as Community Based Adult Services (CBAS), In-Home Supportive Services (IHSS), and the Multipurpose Senior Services Program (MSSP).
- Behavioral Health Treatment (BHT) services have been excluded from the base data as they are included within the BHT supplemental payment. The Comprehensive Diagnostic Evaluation (CDE) costs for the "bridge period" remain in the base data and are no longer carved-out as in previous years.
- Mental health (MH) carve-in projections for the "bridge period" are reflected in the base data which were developed utilizing CY 2016 and CY 2017 RDT experience as well as quarterly health plan reporting from prior MH data requests.
- Seniors and Persons with Disabilities (SPDs)/Full Dual base data was further refined to remove cost and utilization data where Medicare should have been the primary payer.
- In-Lieu of Services (ILOS) were removed from the base data experience.
- Global administrative adjustment assumed that administrative dollars were removed from the payments made by the direct health plan to the global health plan in the development of the base data.

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- Costs for Whole Child Model (WCM) members were removed from the base data for COHS counties as they are now included in the separate WCM rates.
- Downward adjustment of the hospital incentives, to be more in-line with the incentives reported for other Category of Aid (COA) groups as well as other health plans within the Medi-Cal managed care program.
- Reduction of hospital capitation costs reported for the ACA Optional Expansion (OE) COA group.
- Inclusion of adjustments for population acuity, Maximum Allowable Cost (MAC), inappropriate Part B/D spend, and Potentially Preventable Admissions (PPA).
- Program changes were applied for the following:
    - LTC rate increases
    - Hospice rate increases
    - Diabetes Prevention Program
    - Pediatric Palliative Care
    - Medi-Cal Access Program: Mothers transition to managed care in COHS counties
    - Removal of Indian Health Services (IHS)
- Similar to previous years, the administrative load varies by COA group and a lower administration load percentage is applied to the supplemental payments for Hepatitis C, BHT and Health Homes rates.
- Underwriting gain loads for cost of capital and risk are unchanged from SFY 2018–19 rates and remain at 2%, 3%, and 4% at the lower, midpoint, and upper bounds respectively.
- Correction to the Non-Medical Transportation (NMT) impacts consistent with the impacts delivered in June 2019.
- Ground Emergency Medical Transportation (GEMT) add–on: Senate Bill (SB) 523 established the GEMT Quality Assurance Fee (QAF) program result in a per trip rate increase for applicable GEMT service providers.
- Updated LTC adjustment to reflect amounts for the time limited heat detector add–ons.
- CBAS Assembly Bill (AB) 97 buyback – effective July 1, 2019, Medi-Cal will be restoring the AB 97 10% rate reduction previously applied to non–exempt CBAS facilities, as applicable.
- Adult Optional Benefits (Audiology, Speech Therapy, Podiatry, Vision, Incontinence Creams and Washes)
    - Effective January 1, 2020, DHCS restored certain adult optional benefits including vision (excluding lens fabrication), audiology, speech therapy, incontinence creams and washes, and podiatry.
- WCM Spinraza and GEMT program change adjustments have been corrected to accurately apply the contract period impact to the rates resulting in a slight upward adjustment to the final rate.
- Updates to the WCM administrative load Per-Member-Per-Month (PMPM) to account for changes in the underlying medical component.
- Updates to SFY 19–20 WCM county allocation amounts for Medical Management and Care Navigation (MM/CM) to include final county split amounts for these services.
- WCM rates for SFY 19-20 have been refined to calculate program change impacts for the medical component only, aligning with the mainstream rate development process.

Health Homes Program (HHP) Payments

The final rate ranges for the Medi-Cal Health Homes Program (HHP) for Phases 1, 2, 3 and 4 including the contract periods of July 1, 2019 through June 30, 2020 and the following six-month period from July 1, 2020 through December 31, 2020 were sent to CalOptima in August 2019. These final HHP rates contain the following updates:

- Existing Care Coordination (ECC) carve-out: the CY 2017 RDT reporting in Schedule 1-U (UM/QA/CC) has been leveraged for HHP rate development.
    - Previous HHP draft rates utilized CY 2015 and CY 2016 RDT reporting.
    - In the CY 2017 RDT, CalOptima informed DHCS/Mercer of the percentage of the UM/QA/CC experience that was directly related to Care Coordination efforts.
- Updated Targeted Engagement List (TEL)
    - A more recent run of the TEL was used when forecasting HHP enrollment which was the same list provided to CalOptima in June 2019 for the engagement process of the HHP program.
    - The final HHP rate is a blend of the separate Chronic Conditions (CC) only and Serious Mental Illness (SMI) HHP member rates.
    - The CC Only/SMI member mix from the TEL is the primary driver behind the blending percentages.
    - The increase in the mix of less costly CC Only members results in a rate decrease for the blended rate.
- Engagement period updates
    - Health plan feedback regarding the engagement process along with actual enrollment and payment experience through April 2019 (from Phase 1 and 2 health plans) has been leveraged to help inform updates to the engagement period assumptions. These updates impact only the Non-Dual rates since there is no engagement PMPM for the Dual rate.
    - Additional engagement period updates include:
        - Uptake percentage: uptake percentage been updated from 25% to 20%. Recent experience supports the assumption that 1 in 5 TEL members will join the program rather than 1 in 4. This update increases the engagement PMPM by 25% for all Non-Dual rates.
        - Average monthly hours of engagement per TEL member: DHCS updated the average hours of engagement per TEL member from 2.05 to 2.25 (10% increase) for CC Only and from 2.35 to 2.75 (17% increase) for SMI members. This increase results in an ~4% increase for each health plan's SFY 19-20 rate.
        - Engagement in ramp-up timeframe: DHCS modified the assumption regarding how much of the TEL health plans will work through each month. Previous rates assumed health plans would work through one-fourth (25%) of their TEL each month. The updated assumption is that health plans will work through one-eighth (12.5%) of their TEL each month. Therefore, health plans would work through their TEL in 10 months. This slowdown in the ramp up increases the engagement PMPM by ~30%.
- Additional information regarding the HHP rates include the following:
    - Statewide (STW) premiums for CC Only and SMI populations calculated separately.

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- Health plan specific adjustments to the statewide rates and blend the CC Only and SMI rates together based on CalOptima's HHP enrollment projections to produce the final rates for applicable rating periods.
- Health plan rates for the 18-month bridge period split into the SFY 19-20 (12 months) and July through December (6 months) contract periods.
- Comparison of draft SFY 19-20 rate to the final SFY 19-20 rate at the lower bound.
- Build-up of the lower bound HHP services PMPM for CC only and SMI enrollees highlighting the salary and caseload assumptions by HHP staff member, along with the Tier mix assumptions and the provider overhead calculation.
- Buildup of the lower bound engagement period costs for each member on the TEL, including wage and service time assumptions by HHP staff members as well as the assumed average number of months of engagement required for each TEL member.
- 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. The plan-specific ECC PMPM and Partial Dual carve-outs are then applied to create the lower bound Non-Dual rates. The lower bound Full-Dual rates are created by carving out the ECC and CCM/BHI PMPMs.
- Lower bound CC Only and SMI rates are blended together based on projected HHP enrollment to produce contract period rates. Non-medical loads for administration and underwriting gains are also included.

Behavioral Health Treatment (BHT) Payments

BHT supplemental payment rates for the period of July 1, 2019 through December 31, 2020 were sent to CalOptima in June 2019. These final BHT rates contain the following updates:

- Final BHT supplemental payment rate summary for the 18–month "bridge period" with comparison to the prior year SFY 2018–19 BHT supplemental rate.
- One detailed Cost and Reimbursement Comparison Sheet (CRCS) showing the build-up of the rate from the base data up through the gross medical expense for members with Autism Spectrum Disorder (ASD) and the blend with the non-ASD population to produce the final BHT supplemental rate, including administrative and underwriting gain loads.
- Most other components of the BHT supplemental rate development methodology that were utilized for SFY 2018–19 were maintained for this 18–month bridge period including a 2-year base period, global member experience and credibility adjustment.

Hepatitis–C Payments

Hepatitis–C supplemental payment rates for the period of July 1, 2019 through December 31, 2020 were sent to CalOptima in May 2019. The rate exhibits contained detailed rate development for the non–340B Hepatitis C and 340B Hepatitis C supplemental payment. The updated rate represents a 31% decrease from the SFY 2018–19 supplemental payment rate at the lower bound (non–340B). The main factors for the lower payment rate are the following:

- The addition of the two new generic Hepatitis C drugs into the market (generic Epclusa and generic Harvoni) significantly reduces the expected cost of treating Hepatitis C. The treatment cost for generic Epclusa is $24,000 over 12 weeks ($2,000 per week), while generic Harvoni costs $3,000 per week (over an 8-week period).
- Inclusion of a rebate assumption for Mavyret in the rate range development.
- Factoring in the small percentage of members that will require a higher cost treatment, such as Vosevi, but that the majority of members (over 90%) will be able to be treated with the lower cost options of either generic Harvoni/Epclusa or Mavyret.

Abortion (Hyde) Payments and Proposition 56 Add–On

Abortion (Hyde) payments for the period of July 1, 2019 through December 31, 2020 were first sent to CalOptima as draft rates in May 2019 and as updated draft rates in November 2019. The Hyde rates contain two summary tabs. The two summary tabs reflect the rates for CalOptima for the 12–month (July 1, 2019 to June 30, 2020) and the 6–month (July 1, 2020 to December 31, 2020) time periods of the overall 18–month bridge period. The underlying Hyde rates displayed on these summaries have not changed since they were previously sent to CalOptima. The only change was the inclusion of the Proposition 56 add-on amounts.

Proposition 56 Directed Payments

DHCS sent CalOptima exhibits reflecting CalOptima's Proposition 56–Physicians PMPM add–on amounts for July 2019 to December 2020 in November 2019 and updated Prop 56 directed payments in July 2020. Rate add-ons for each Proposition 56 initiative (Physician Directed, Trauma Screening, Developmental Screening, Family Planning and Value Based Purchasing) are included. Highlights regarding these amounts include the following:

- Recalculations of the trauma and developmental screening add-on PMPMs; Prop 56 add-on PMPMs for Physician, Value Based Purchasing (VBP) and Family Planning remain unchanged.
- For each initiative, the PMPM add-on amounts are consistent between 12 months and 6 months for each rate cell even though all five initiatives are not effective July 1, 2019.
- For the Trauma and Developmental Screening screenings, which are not effective until January 1, 2020, the PMPM add-on amounts for the 12-month effective period (January 1, 2020 to December 31, 2020) have been spread evenly over the entire 18–month bridge period.
- The Physician Directed, Trauma Screening, and Developmental Screening PMPM add-ons are subject to a collective two-sided risk corridor effective for the entire 18–month rating period while the Family Planning and Value-Based Purchasing PMPM add-ons are subject to two separate two-sided risk corridors.
- Part B eligible member experience has been excluded.
- Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Cost-Based Reimbursement Clinics (CBRCs) and Indian Health Services (IHS) utilization is excluded from the final PMPM add-on development for Physician Directed, Family Planning, and Value Based Purchasing as services at these facilities are not eligible for enhanced provider payments per the policies of the three initiatives.

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- For Physician Directed Proposition 56, the 18–month bridge rating period estimates were developed using a rate development methodology consistent with the State Fiscal Year (SFY) 2018–19 estimates.
- Calendar Year (CY) 2017 health plan-reported supplemental data request (SDR) experience was utilized along with CY 2017 encounters.
- For Physician Directed Proposition 56, the underlying dollar add-ons for each CPT code have not changed from the SFY 2018–19 rating period.
- The exhibits include utilization per 1,000 members, the unit cost (the average enhanced payment amount for applicable codes) and the resulting PMPM add-on amounts.
- The final PMPM add-on amounts include administrative load (3.375%) and underwriting gain (2%).

Coordinated Care Initiative (CCI) Non–Full Dual and Partial–Dual Rate Ranges

CalOptima received CCI non-full dual draft rates for July 2019 through December 2020 in August 2019, updated draft rates in November 2019 and final rates in March 2020. Highlights regarding these final rates are as follows:

- The rate exhibits include county-wide base member months and the total payment rate for each category of aid (COA), inclusive of administrative and underwriting gain loads.
- The county–specific CRCS display the lower bound category of service (COS) detail on the development of the rates from the finalized base data through to the gross medical expense, accounting for trend, policy changes and managed care/efficiency adjustments and concluding with the application of the fixed/variable administrative and underwriting gain loads to produce the lower bound of the final capitation rate range.
- The rate includes the following program changes: Ground Emergency Medical Transportation (GEMT), MSSP rate increase, AB 97 buyback for CBAS, and updated LTC rate increases along with the hospice rate increase and NMT amounts included in the previous version of the rates.
- The rates reflect a rebase that utilizes CY 2017 experience including plan-submitted RDTs and encounter data.
- Current financial experience was reviewed primarily for the administration and underwriting gain loads.
- The rebase includes base data adjustments that were applied to In Lieu of Services (ILOS) and global administrative adjustments.
- IHSS care coordination costs and associated administration and underwriting gain that was formerly in CalOptima's CCI Non-Dual Home and Community-Based Services (HCBS) High COA are being accounted for in CalOptima's non-CCI base data and rates.
- The CCI Non-Dual HCBS Low COA supplemental payment will end as of the June 30, 2019 service period.
- Base rate with applicable add-on including Proposition 56 add–ons (Physician Directed, Trauma Screening, Developmental Screening, Family Planning and Value Based Purchasing).
- The MCO tax and HQAF add-ons are included in the total add-ons displayed.

Calendar Year (CY) 2019 Coordinated Care Initiative (CCI) Full Dual Rate Ranges

CalOptima received draft CY 2019 CCI full dual rates for January 2019 through December 2019 in December 2019 and updated draft rates in May 2020. The revised rates were submitted to CMS on May 1, 2020 to account for an MCO Tax update as outlined below:

- The draft MCO Tax PMPMs previously shared with the MCPs assumed CMS approval for the full 3.5-year period (July 2019 to December 2022), which is no longer applicable.
- The finalized rate methodology approved by CMS is only for the three-year period of January 2020 through December 2022.
- The MCO Tax PMPMs for the period of July 2019 through December 2020 have been removed from the CY 2019 CCI Full Dual rate ranges.

These rates reflect a rate rebase that now utilizes CY 2017 experience including plan submitted Rate Development Templates (RDTs) and encounter data. Current financial experience has also been reviewed as part of this process primarily for the Administration and Underwriting Gain loads. Highlights regarding these draft rates are as follows:

- Base data adjustments: The base data adjustments applied are the following:
    - In Lieu of Services (ILOS)–appropriately reported ILOS costs reported in the Schedule 1–L were removed from the base data experience.
    - Global admin adjustment – for health plans who globally subcontract to another health plan, assumed administrative dollars were removed from the payments made by the direct health plan to the global health plan in the development of the base data.
    - In–Home Supportive Services (IHSS) Removal – Consistent with rates effective January 1, 2018, IHSS is no longer a Medi-Cal managed care benefit.
- The program changes applied include:
    - Long-Term Care (LTC) rate increases
    - Hospice rate increases
    - Non-Medical Transportation (NMT) – Amounts built in for NMT were developed using the health plan submitted NMT supplemental data request (SDR) information.
    - Ground Emergency Medical Transportation (GEMT) Add–On – Senate Bill (SB) 523 established GEMT Quality Assurance Fee (QAF) program resulting in a per trip rate increase for GEMT service providers.
    - CBAS AB 97 buyback – Effective July 1, 2019, Medi-Cal will be restoring the AB 97 10% rate reduction previously applied to non-exempt CBAS facilities.
    - MSSP rate increase – Effective July 1, 2019, the Medi-Cal reimbursement rate for MSSP services will increase 25%.
- Capitation Rate Calculation Sheets (CRCS) which display the county–specific category of service detail on the development of the rates from the finalized base data through to the gross medical expense, accounting for trend, policy changes and managed care/efficiency adjustments.
    - The calculation concludes with the application of the administrative and underwriting gain loads to produce the final county-specific rates.
- Capitation rates summary which displays information for the CMC Eligible populations and a second one for the CMC Ineligible population as follows:

  - CMC Eligible – The base rate displays the county-wide base member months and the total payment rate for each category of aid, inclusive of administrative and underwriting gain loads as detailed in the CRCS.
    - This section is followed by the "CMC Enrolled" information that utilizes a Plan-specific CMC contract period mix assumption along with the Category of Aid (COA) base rate information to calculate the final lower bound, midpoint, and upper bound blended CMC rates.
    - The final two tables on the tab in this rate summary utilize a Plan-specific Eligible But Not Enrolled (EBNE) contract period mix assumption along with the COA-specific base rate information to calculate the final lower bound, midpoint, and upper bound blended EBNE rates.
    - The first of these two tables incorporate the SFY 2018-19 MCO Tax PMPMs and is applicable for January through June 2019, while the second table incorporates the "bridge period" MCO Tax PMPMs and is effective for July through December 2019.
  - CMC Ineligible – The base rate displays the county-wide base member months and the total payment rate for each COA, inclusive of administrative and underwriting gain loads as detailed in the CRCS.
    - This section also includes two tables that utilize a plan-specific CMC Ineligible contract period mix assumption along with the COA-specific base rate information to calculate the final lower bound, midpoint, and upper bound blended CMC Ineligible rates.
    - The first table incorporates SFY 2018–19 MCO Tax PMPMs and is applicable for January through June 2019, while the second table incorporates the "bridge period" MCO Tax PMPMs and is effective July to December 2019.
- Non-Cal MediConnect Full Dual Capitation Rates Summary brings together both the EBNE and the CMC Ineligible final plan-specific rates and show the final, blended CY 2019 Non-CMC (i.e. MLTSS) Full Dual rate range based on the Phase III prospective member mix.
  - For blended Non-CMC rate ranges, the displayed rates incorporate the impact of the MCO Tax PMPMs for both the first half (January through June) and the second (July through December) of CY 2019.
  - For CMC, the displayed rate increments reflect the application of the appropriate CY 2019 savings percentage, but not of the 3% quality withhold.

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section.

Fiscal Impact

The recommended action to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to rate changes for the period covering July 2019, through December 2020 is expected to be budget neutral. Prior to Fiscal Year (FY) 2019-20 year-end, Staff integrated the final rates into the CalOptima financial statements, and so these have been appropriately reflected. The CalOptima FY 2020-21 Operating Budget, approved by the BOD on June 4, 2020, included draft rates comparable to the rates contained in this amendment. Staff anticipates no material differences.

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This amendment includes a 1.5% reduction to Child, Adult, ACA OE and SPD members for the Bridge Period. This reduction is one of the main drivers of the Medi-Cal line of business deficit in the FY 2020-21 Operating Budget. The amendment also includes the GME risk corridor approved in the FY 2020-21 State Budget. DHCS will perform the reconciliation retrospectively. Without final guidance, currently the outcome of the risk corridor application and overall impact to CalOptima's financials are unknown. In the event there are material differences between the logic outcome and budget assumptions, Staff will reflect the fiscal impact in future CalOptima financial statements.

Rationale for Recommendation

DHCS develops capitation rates according to base data reported by CalOptima through the Rate Development Template (RDT) process and adjusted for trends and program changes. Execution of the contract amendment will ensure revenues, expenses and cash payment are consistent with the approved budget to support CalOptima operations.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Richard Sanchez *09/23/2020*

Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 25

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A-45 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010

A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval

A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Action
Ratify the amendment to the current Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, November 5, 2020.

Background
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Kaiser's current Health Network Contract expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS-required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments.

CalOptima and Kaiser staff worked with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. To allow time for Kaiser and CalOptima to obtain all necessary information and final clarification from DHCS and complete discussions regarding the Amended and Restated Contract, the parties entered into an initial ninety (90) day extension of Kaiser's current contract through September 30, 2020. Due to the June 30, 2020 expiration date of the current Kaiser Health Network Contract, this extension was ratified by the Board on August 6, 2020.

Discussion
The parties continue to review certain provisions of the Amended and Restated Contract that memorialize operational requirements in light of Kaiser's unique model as well as the five (5) subsequent amendments that implement Prop 56, Health Homes Program requirements and other terms (Contract Amendments). Additionally, because Kaiser is the only CalOptima Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser staff are addressing terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract when the State implements its Medi-Cal Rx program effective January 1, 2021 including, revised rates and DHCS-mandated transition terms.

While CalOptima and Kaiser staff have attempted to complete all contract and amendment revisions by September 30, 2020, it will take another thirty (30) days to finalize these issues. Kaiser has requested an additional thirty (30) day extension of the current Kaiser Contract on the same terms and conditions to complete the discussions and finalize the Amended and Restated Contract and Contract Amendments. Because Staff intends to present the final Kaiser Amended and Restated Contract and Contract

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Amendments to the Board for approval at the November 5, 2020 meeting, Staff requests that the Board ratify the extension of the current Kaiser Health Network Contract through that date.

Fiscal Impact

The recommended action to amend the current Kaiser Health Network Contract to extend the term through November 5, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Amending the current Kaiser Health Network Contract to extend through November 5, 2020, the date of the Board's next meeting, under the same terms and conditions will allow the additional time needed to review and finalize Kaiser's FY 2020-21 Amended and Restated Health Network Contract.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 6, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract"

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
8. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment

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

Recommended Actions
Ratify the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020.

Background/Discussion
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Each of CalOptima's contracts with its 12 twelve Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments. Kaiser's current Health Network Contract ("Kaiser Contract") expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments. Kaiser has not, however, executed the Amended and Restated Contract. CalOptima and Kaiser have been working with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. The parties have also been reviewing certain contract provisions that memorialize operational requirements in light of Kaiser's unique staff model.

In order to allow time for Kaiser and CalOptima to obtain final clarification from DHCS and finalize discussions with Kaiser, the parties entered into a ninety (90) day extension of the Kaiser Contract through September 30, 2020, subject to Board approval. Additionally, because Kaiser is the only Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser also need to address contract terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract. The pharmacy benefit carve-out will be effective January 1, 2021 for all Managed Care Plans, including CalOptima.

Staff recommends ratification of the Kaiser Contract amendment to provide additional time to obtain DHCS's final guidance, and for the parties to reach agreement on the Amended and Restated Contract terms.

Fiscal Impact
The recommended action to ratify the amendment to the Kaiser Contract to extend the term through September 30, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020.

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Rationale for Recommendation

This extension will allow additional time to review and finalize Kaiser's FY 2020-21 Health Network contract.

.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated June 4, 2020; "Authorize Extension and Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Kaiser Permanente

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to Amend the Behavioral Health Care Services Contract with the Orange County Health Care Agency (County of Orange) to:

1. Extend the contract through December 31, 2021; and
2. Add language incorporating the provision of opioid use disorder treatment into the contract

Background

With Board approval granted in April 2013, CalOptima entered into a Behavioral Health Care Services Contract with the County of Orange (County). Under this contract, OneCare and OneCare Connect members with serious and persistent mental illness can receive certain Medicare reimbursable mental health services under the County's Behavioral Health programs. This contract was most recently renewed via amendment in 2017, until December 31, 2020, with two (2) additional one-year (1) renewal terms, subject to CalOptima Board and Health Care Agency approval. The processes that have been put in place with the Orange County Health Care Agency for the coordination of care and provision of Medicare-covered behavioral health services have provided much needed services to CalOptima's OneCare and OneCare Connect members since 2013.

Discussion

As of January 2020, the Centers for Medicare & Medicaid Services (CMS) established the Opioid Treatment Program (OTP) as a benefit under Medicare, requiring all Medicare Advantage Plans, including CalOptima, to participate effective January 1, 2020. OTPs provide medication assisted treatment in combination with counseling and behavioral therapies to offer a "whole-person" approach to treating opioid use disorders. Under the Calendar Year 2020 Physician Fee Schedule final rule, Medicare will cover opioid use disorders treatment services for members having Medicare Part B (OneCare and OneCare Connect), effectively transferring financial responsibility from the Drug Medi-Cal program to Medicare. As a Medicare Advantage Special Needs Plan (D-SNP), and Cal MediConnect Plan (Coordinated Care Initiative), CalOptima will make this service available to OneCare and OneCare Connect members through contracted, Medicare approved treatment centers.

To ensure continuity of Behavioral Health Services, including the provision of opioid use disorders treatment for OneCare and OneCare Connect members, staff requests approval to enter into amendments with the County to exercise the first one-year (1) extension and add language reflecting the provision of opioid use disorders treatment as a covered outpatient service.

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Fiscal Impact

The recommended action to extend the Behavioral Health Care Services Contract with the County of Orange through December 31, 2021, and to add language incorporating the provision of opioid use disorder treatment for the OneCare and OneCare Connect programs is expected to be budget neutral.

Rationale for Recommendation

Amending the Contract with the Orange County Health Care Agency will ensure continued access to Behavioral Health Services, including opioid use disorders treatment, for CalOptima's OneCare and OneCare Connect members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated December 7, 2017

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Authorizing Extension of the Coordination and Provision of Behavioral Health Care Services Contract Between CalOptima and the County of Orange, Through its Division the Orange County Health Care Agency, that Expires December 31, 2017

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Donald Sharps, Medical Director, Behavioral Health Integration, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) or his designee, with the assistance of legal counsel, to enter into an amendment to the OneCare and OneCare Connect Coordination and Provision of Behavioral Healthcare Services Contract between CalOptima and the County of Orange through its division the Orange County Health Care Agency (HCA) to extend the agreement through ~~June 30, 2018, with four (4) additional one-year extension options,~~ December 31, 2020, with two (2) one-year extension options, exercisable upon approval by the CalOptima Board and the County of Orange.

Rev 12/7/2017

Background/Discussion

At the April, 4, 2013 Board of Directors meeting, the Board authorized the CEO to enter into the Coordination and Provision of Behavioral Healthcare Services Contract with the County of Orange for the provision of certain Medicare reimbursable mental health services to OneCare members with a serious and persistent mental illness (SPMI) who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the Mental Health Services Act (MHSA).

Based on the January 3, 2013 Board action, this contract was amended in 2013 to add the Duals Demonstration (OneCare Connect) program. Following DHCS instruction dated February 21, 2014 which delayed the program start to July 1, 2014, and a subsequent DHCS delay to July 1, 2015, , the contract was amended again in 2015 to specify that the OneCare Connect program would begin no sooner than July 1, 2015, and that the contract would remain in effect through December 31, 2017.

CalOptima staff is requesting Board approval to extend this contract through June 30, 2018. The contract with the County of Orange is on a fixed term basis requiring a contract amendment for any approved extension. CalOptima staff requests that, the contract term language be modified in a fashion similar to other CalOptima provider contracts. In addition to the extension through June 30, 2018, staff is requesting authority to amend the contract so that it may renew on a fiscal year basis, for four (4) additional one-year terms, each exercisable upon CalOptima Board and County approval.

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Fiscal Impact
The recommended action to authorize the extension of the Behavioral Health Care Services Contract between CalOptima and the Orange County HCA for the OneCare and OneCare Connect programs is expected to be budget neutral.

Rationale for Recommendation
The extension of this contract will support the processes that have been put in place with the Orange County Health Care Agency for the coordination of care and provision of Medicare-covered behavioral health services to ensure that members received needed services. As such, staff requests that the Board authorize amendment of the current Coordination and Provision of Behavioral Healthcare Services Contract as recommended.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated January 3, 2013, Authorize the Chief Executive Officer to Develop a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development
2. Board Action dated April 4, 2013, Authorize the Chief Executive Officer (CEO) to Contract with the County of Orange and its Subcontracted Providers for the Provision of Certain Behavioral Health Services to OneCare Members with a Serious and Persistent Mental Illness (SPMI) and to Amend CalOptima's Contract with Windstone Behavioral Health (Windstone) to Clarify Its Obligations with Regard to the Provision of Certain Behavioral Health Services to OneCare members with SPMI

/s/ Michael Schrader — *11/30/2017*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 3, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. E. Authorize the Chief Executive Officer to Develop a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development

Contact

Javier Sanchez, Executive Director, CalOptima Care Network, (714) 246-8400

Recommended Actions

1. Ratify amendments to existing and currently approved OneCare Participating Medical Group (PMG), Hospital and Ancillary medical provider contracts which include the stated intent to participate in the Duals Demonstration, with the final contract terms subject to future Board approval; and
2. Authorize the Chief Executive Officer to expand the provider delivery system for the purpose of preparing for the implementation of the Duals Demonstration, including conducting related financial modeling, development of contract templates with the assistance of legal counsel, and including the following:
    a. Issuing a Request for Proposal (RFP) to seek proposals from health care entities including those not currently contracted with OneCare such as organized medical groups and health plans which desire to contract with CalOptima to provide services as part of the Duals Demonstration through alternative financial/ risk delegation models; and authorize staff to use existing OneCare criteria to evaluate providers' delegation readiness, as applicable, and subject to refinement based on final Duals Demonstration requirements;
    b. If necessary for continuity of care, utilizing the CalOptima Care Network (CCN) to serve Duals Demonstration members through CCN's directly contracted network of providers; and
    c. Authorizing the CEO, with the assistance of legal counsel, to enter into Letters of Intent (LOI) with selected RFP responders memorializing the intent to participate in the Duals Demonstration. The final contract terms are subject to future Board approval, as well as state and federal approval, as required.

1/3/13: Recommended action #2 continued for 30 days.

Background

CalOptima currently serves approximately 74,000 members who are dually eligible for both Medicare and Medi-Cal ("dual eligibles"). The CalOptima Board previously approved CalOptima's intention to partner with both the federal and state governments to establish a Duals Demonstration for dually eligible individuals in Orange County. As a Duals Demonstration Plan, CalOptima would be able to coordinate the full array of health care benefits for dually eligible individuals, including both Medicare covered benefits, Medi-Cal covered wrap-around services and Medi-Cal Long Term Services and Supports.

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At its May 2012 meeting, the CalOptima Board authorized the CEO to complete and submit an application to CMS and the DHCS to obtain designation as a Duals Demonstration. At that time, the Board also authorized the CEO to spend pre-implementation startup costs of not-to-exceed $373,994 to secure the necessary resources to meet regulatory requirements for the development of the Demonstration. The initial application requirements were submitted and staff continues to respond to additional inquiries regarding the application. CMS and DHCS plan to conduct plan readiness assessments in October or November 2012.

While Duals Demonstration details are in the process of being finalized by CMS and DHCS, management's understanding is that the proposed method of enrollment of members into the Demonstration is through passive enrollment of members who do not actively opt out. This is similar to the approach used at the start of CalOptima's OneCare program in 2005. At that time, there were approximately 55,000 dual eligible members in Orange County. Most of these individuals were passively enrolled into OneCare; however, within several months of OneCare's start-up, approximately 75% of these individuals actively disenrolled from the program. While OneCare has experienced steady and consistent growth since inception, it continues to experience the disenrollment of members who are unable to access providers not contracted with OneCare.

Discussion

The potential enrollment for the first year of the Duals Demonstration is projected to be approximately 50,000 Orange County dual eligible members currently in fee-for-service (FFS). Enrollment is scheduled to begin in June 2013 and will continue for 12 months. To ensure member continuity of care to the fullest extent feasible under the Demonstration, CalOptima staff desires to engage providers who already serve dual eligible members in FFS Medicare but have not participated in OneCare to their fullest capacity, do not contract with one of CalOptima's contracted PMGs under the OneCare program, or do not currently contract with CalOptima at all. Inclusion of providers that currently serve members in FFS Medicare would ensure adequate network capacity, geographic coverage and cultural competence and would support member engagement in the Demonstration.

Stakeholder Vetting Process

The Board's Provider Advisory Committee (PAC) recently undertook an input and vetting process that included formation of an ad hoc workgroup to consider options for the duals demonstration provider delivery system and offer guidance regarding provider engagement. The workgroup's recommendations regarding delivery system expansion and options for provider participation were approved by the PAC at its June 14, 2012 meeting. The recommendations have been incorporated into this proposal, summarized in the subsequent section.

The ad hoc workgroup, which includes representatives from hospitals, trade associations CalOptima's contracted health networks, HMOs, some ancillary and DME providers, as well as

individual medical providers, and other stakeholders continues to meet weekly to develop recommendations to maximize provider participation in the duals demonstration.

Building on CalOptima's OneCare Provider Network

CalOptima was selected to participate in the Duals Demonstration in part because of its experience providing quality of care to dual eligible members in the OneCare program. Staff's proposal is to leverage the OneCare provider network of currently contracted medical groups, hospital and ancillary providers, and additional medical groups approved to participate in the near future, as the basis for the Duals Delivery system. In preparation for the joint CMS and DHCS plan readiness review, staff proposes to leverage existing OneCare contracts. While the final readiness requirements have not been released, staff anticipates that both CMS and DHCS will require plans to provide signed contracts to demonstrate a provider network. For this reason, it is necessary to ratify amendments that were executed with currently contracted PMGs, which state the provider's intent to enter into a contract with CalOptima for the Duals Demonstration subject to the negotiation of final contract terms and Board approval.

Provider Delivery System Expansion

Staff recommends expanding on the existing OneCare delivery system to execute a successful Duals Demonstration that includes as many provider choice options for the 50,000 dual eligibles currently in FFS Medicare as possible. To achieve one of the important the goals of the Demonstration to maintain continuity of care and member/physician relationships for Duals who choose or are passively enrolled in the Dual Demonstration, it is imperative that CalOptima allow flexible options to participate in the Duals Demonstration for providers who currently provide services to Duals outside of CalOptima in Medicare FFS. CalOptima's experience in OneCare from start up indicate that if members are not able to maintain access to providers of their choice, members will exercise their right to disenroll from the Demonstration. The RFP process would allow providers to express their preferred means of participating in the Duals Demonstration:

- Full Delegation/Full Risk (available only in Medi-Cal currently)
- Partial Delegation/Partial Risk – includes Shared Risk (SRG) or Physician Hospital Consortia (PHC) (available in Medi-Cal and OneCare)
- Direct Contract/No Delegation (available only in Medi-Cal currently for limited diagnoses)
- Minimal Delegation (not available currently)

Currently participating delegated medical groups would also have an opportunity to propose new ways to participate in the CalOptima delivery system. For example, current Shared Risk Groups may propose future participation as Full Risk medical groups. Review criteria for such proposals would include evaluation of whether the requesting provider(s) meet the appropriate regulatory risk bearing organization and CalOptima criteria.

This process would also include the development of a contract template for each contracting option to be provided to interested providers. By offering additional contracting options, CalOptima staff anticipates engaging providers who have not traditionally participated with CalOptima (e.g., Medicare FFS providers), as well as expanding opportunities for currently contracted providers. As an example, two HMOs and three health networks currently contracted in CalOptima's Medi-Cal program are not OneCare providers.

CalOptima would enter into LOIs with providers interested in participating in the Duals Demonstration. Once rates are provided, CalOptima staff intends to develop a provider payment methodology that is based on Medicare rates, subject to final negotiations with DHCS and CMS. The final financial aspects of the Duals Demonstration will be provided to the Board for final approval in conjunction with proposed provider contract terms associated with all contracting options and a proposed agreement with DHCS and CMS.

RFP and Evaluation Process

CalOptima would request proposals (RFP) from medical groups and health plans interested in participating as Full Delegation/Full Risk and Minimal Delegation providers. CalOptima intends to evaluate providers and groups based on their ability to meet the minimum quality, administrative and financial participation criteria. Staff is in the process of developing the formal scoring criteria that will be used to evaluate the RFP responses with the assistance of a M.D. Medical Management consultant specializing in network structure. Such criteria would be approved by the Board and would include, but would not be limited to the following:

1. Medi-Cal Managed care experience
2. A requirement to participate in CalOptima's Medi-Cal and Medicare programs
3. A requirement to serve all CalOptima member categories and ages eligible for health network enrollment
4. Applicants must demonstrate the ability to add new providers not currently participating in the CalOptima system
5. Capacity to service seniors and persons with disabilities
6. Accreditation Status (Hospitals must be Joint Commission accredited)
7. Administrative capacity to perform:
    a. Utilization management
    b. Medical management
    c. Credentialing
    d. Quality management
    e. Claims processing and adjudication
    f. Member services and customer service functions
    g. Electronic data interchange
8. SB 260 compliance
9. Financial solvency

10. Financial reserve requirements
11. Cultural and linguistic services
12. Coordination with carve-out agencies
13. Demonstrated capacity to provide, or written subcontracts for the provision of, all covered services, as defined in the Division of Financial Responsibility (DOFR) provided by CalOptima
14. A history of quality patient care and member satisfaction as demonstrated through HEDIS or other approved measures

Recognizing the different strengths and weaknesses among the various groups and the need to maintain as many qualified participating providers as possible, CalOptima staff plans to work with health networks and providers independently in an effort to determine the optimal relationship for all parties involved.

Letters of Intent

To secure a robust delivery system and provider network that offers the best opportunity for a successful Duals Demonstration, it is necessary for CalOptima to secure LOIs with providers ahead of the start date of the Demonstration. Due to the lack of rates and final contractual terms associated with the Demonstration, the only option available to CalOptima is to enter into Letters of Intent (LOI) with down-stream providers selected according to the proposed process described above. With assistance of Legal Counsel, CalOptima staff would draft and execute LOI with providers subject to the final contract terms are to be negotiated and subject to future Board approval.

Fiscal Impact

Significant financial analysis will be performed once the rates for the Duals Demonstration are determined. The Board will have the opportunity to assess CalOptima's participation in the Duals Demonstration and the associated delivery system once rates are received. The rates paid to CalOptima are expected to be based on the current medical costs for Dual Demonstration eligibles, with reductions to generate savings to the State and CMS from the program. The rates paid to providers will be based on the rates paid to CalOptima. CalOptima's best opportunity to mitigate financial risks is to achieve the broadest network of physicians and largest number of members possible. The more CalOptima's Duals Demonstration membership is reflective of the Orange County duals population as a whole, then the more likely the payment rates provided under the program will be adequate. CalOptima will be fully financially responsible for duals that may be served in CCN and will implement a coordinated model of care consistent with prevailing managed care principles in Orange County. CalOptima expects to reduce medical expenses and contribute additional margin as it manages these previously unmanaged members to a medical expense per member more similar to medical expense experience in a managed population.

Rationale for Recommendation

Successful implementation of the Duals Demonstration is predicated in large part on the establishment of a network that includes providers who may not have fully participated with CalOptima or have not contracted with CalOptima previously and are currently providing services for CalOptima dual eligible members in FFS Medicare. To engage these providers, CalOptima recommends the Board consider expanding the Duals Demonstration delivery system to offer a flexible participation model that aligns providers' organizational capacity with their level of desired risk.

Concurrence

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

Attachments

None

/s/ Michael H. Ewing — **Authorized Signature**

12/21/12 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. H. Authorize the Chief Executive Officer (CEO) to Contract with the County of Orange and its Subcontracted Providers for the Provision of Certain Behavioral Health Services to OneCare Members with a Serious and Persistent Mental Illness (SPMI) and to Amend CalOptima's Contract with Windstone Behavioral Health (Windstone) to Clarify Its Obligations with Regard to the Provision of Certain Behavioral Health Services to OneCare Members with a SPMI

Contact

Clayton Chau, M.D., Medical Director, Behavioral Health, (714) 246-8400

Recommended Actions

Authorize the CEO to:

1. Enter into contracts with the County of Orange and its subcontracted providers for the provision of certain Medicare-reimbursable mental health services to OneCare members with a serious and persistent mental illness (SPMI) who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the Mental Health Services Act (MHSA).
2. Amend CalOptima's current contract with Windstone to clarify its obligations with regard to the provision of these services.

Background

CalOptima's OneCare HMO SNP program is responsible for mental health services covered by Medicare. CalOptima has delegated responsibility for the coordination and provision of outpatient mental health services to Windstone since the inception of the OneCare program. CalOptima pays Windstone a per-member-per-month (PMPM) capitation payment for covering and coordinating outpatient and inpatient professional services for OneCare members, including discharge planning and transition from the inpatient setting.

Discussion

In 2012, CalOptima identified that it is necessary for OneCare members with a SPMI, who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the MHSA through the County of Orange, to receive their care through those programs. Examples of additional services provided through the county programs include socialization activities, recovery support groups, supported housing program, peer led activities, and medication review and education. At any given time, there are approximately 200 OneCare members who require these services.

As proposed, CalOptima will pay the County of Orange and its contracted programs for the Medicare-covered services (directly to the programs) on a fee-for-service (FFS) basis at 80% of the Medicare fee schedule. The programs have agreed to accept this rate. CalOptima will

continue to pay a capitation payment to Windstone Behavioral Health for OneCare members while the members are receiving the higher level of outpatient care through the County of Orange and its contracted programs. Windstone will have responsibility for inpatient professional services for these members, including discharge planning and transition from the inpatient setting. In addition, Windstone will coordinate with the County of Orange and its contracted programs for transition to the community level of outpatient care when the member has reached the appropriate level of recovery. Windstone's capitation payments have been adjusted to account for the services paid to the County of Orange and its subcontracted providers on a FFS basis.

CalOptima is currently in discussions with the County of Orange to enter into a formal contract to establish the terms of this agreement to provide services to SPMI members. As proposed, in the meantime, CalOptima will continue to pay for these services on a non-contracted out-of-network FFS basis. CalOptima is also in the process of amending Windstone's current contract to stipulate its responsibilities for coordinating the care of OneCare members who receive outpatient mental health services through the County of Orange and its subcontracted providers.

Fiscal Impact
Payments for these programs during 2012 were less than $100,000. While increased volume is expected based on improved access, minimal financial impact is expected since the FFS payments to the County of Orange and its subcontracted providers is offset by the capitation rate change to Windstone.

Rationale for Recommendation
The proposed approach provides OneCare members with access to the most appropriate level of care in a manner that is seamless to them and based on their clinical need. Access to the Medi-Cal and MHSA-funded components provides OneCare members with the best opportunity for recovery, leading to the combined outcome of a healthier member and reduced system costs.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *3/29/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
28. Consider Approval of Modifications to Quality Improvement Policies

Contacts
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8400

Recommended Actions
Approve modifications to the following CalOptima policies pursuant to CalOptima's annual review process:

- GG.1650: Credentialing and Recredentialing of Practitioners
- GG.1633: Board Certification Requirements for Physicians

Background/Discussion

Proposed Modifications to Existing Quality Improvement Policies and Procedures
CalOptima staff regularly reviews agency policies to ensure they are up to date and aligned with federal and state health care program requirements, regulatory and contractual obligations, as well as CalOptima operations.

Below are the existing Quality Improvement policies that required modifications:

- ***GG.1650: Credentialing and Recredentialing of Practitioners [Medi-Cal, OneCare, OneCare Connect and PACE]*** describes the process by which CalOptima evaluates and determines whether to approve or decline practitioners for participation in CalOptima programs. CalOptima staff proposes revisions to this policy pursuant to the CalOptima annual review process including revisions to who should be credentialed or recredentialed, including Non-Physician Medical Practitioners (NMP) as outlined in Section II.F and Section II.G. There are also several proposed updates to the Glossary section.
- ***GG.1633: Board Certification Requirements for Physicians [Medi-Cal, OneCare, OneCare Connect and PACE]*** describes CalOptima's requirement for board certification of contracted physicians. CalOptima staff proposes revisions to this policy pursuant to the CalOptima annual review process including the addition of Board Certification Entities as outlined in Section III.C and the removal of "Recognized Board Certificates" definition from the Glossary section.

Fiscal Impact
The recommended action to approve revisions to CalOptima Policies GG.1650 and GG.1633 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget.

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Rationale for Recommendation

The recommended action will ensure CalOptima is compliant with contractual and regulatory guidance provided by its regulators (e.g., Department of Health Care Services and Centers for Medicare & Medicaid Services). The updated policies will supersede the prior versions.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. GG.1650: Credentialing and Recredentialing of Practitioners Final Policy Packet
2. GG.1633: Board Certification Requirements for Physicians Final Policy Packet

/s/ Richard Sanchez — **Authorized Signature**

09/23/2020 — **Date**

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Policy:	GG.1650Δ
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	06/01/2017
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 2020 1001 BOD Review Only

I. PURPOSE

This policy defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select Practitioners to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, Section 422.204(a) and other applicable laws, regulations, and guidance.

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network or other Delegate in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities. Delegated activities may include but are not limited to: Credentialing decisions, Credentialing verification, monitoring of sanctions, and processing of Credentialing applications.

1. A Health Network or Delegate shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO) or his or her physician Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities shall include but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving provider files, and ensuring credentialing policies are adhered to.

D. The CalOptima ~~Credentialing Peer Review Committee (~~CPRC~~)~~ shall be responsible for reviewing a Practitioner's Credentialing information and determining such ~~practitioner's~~Practitioner's participation in CalOptima.

E. CalOptima shall ~~Credential~~credential and ~~Recredential~~recredential the following Practitioners as provided in this Policy: Physicians, Non-Physicians Medical Practitioners, Behavioral Health

Practitioners, Substance Use Disorder (SUD) Practitioners, and Long Term Services and Supports (LTSS) Practitioners that provide care to CalOptima program Members, and are:

1. Licensed, ~~Certified~~certified, or registered by the state of California to practice independently ~~and~~;

2. Contracted with CalOptima to provide care under CalOptima's programs (including ~~physicians practicing at~~those Practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary and Specialty Care services.~~)~~; and

3. Who provide care to Members under the organization's medical benefits.

F. Credentialing and recredentialing shall apply to Practitioners meeting the criteria in Section II.E. of this Policy, regardless of whether they provide care:

1. In individual or group practices;

2. In facilities; or

3. Through telemedicine/telehealth i.e., virtual care visit.

~~F.~~G. CalOptima shall credential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and do not have an independent relationship with CalOptima~~, as follows~~ including:

1. ~~For~~ NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner ~~who has~~and have executed a signed ~~Delegation Services Agreement~~agreement as required by the applicable state of California board with the NMP; or

2. ~~Under~~NMPs who provide services as part of an Organized health Care System that is credentialed with CalOptima and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

~~2.~~3. NMPs who are not PAs and who provide services under the employment agreement of a credentialed Provider.

~~G.~~H. An NMP shall notify CalOptima immediately if the supervising Physician Practitioner no longer meets the CalOptima Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or employment with the entity or Organized Health System.

~~H.~~I. CalOptima does not ~~Credential~~credential or ~~Recredential~~recredential:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provide care for a Member only as a result of the Member being directed to the hospital, or inpatient, setting;

2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates Utilization Management (UM) functions (Credentialing of Pharmacies and its professional and

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technical staff shall be conducted by the PBM, in accordance with CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access);

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima; and

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer).

~~I.~~J. CalOptima shall ~~categorize Practitioners into the three (3) Fraud, Waste, and Abuse risk levels established by the Centers~~ensure that any provider for ~~Medicare & Medicaid Services (CMS): limited, moderate, and high, and will screen Practitioners for the appropriate risk level in accordance with~~ whose provider type has an enrollment pathway with Department of Health Care Services (DHCS) is enrolled with DHCS as a provider in accordance with DHCS All Plan Letter (APL) ~~17-019~~19-004: Provider Credentialing / Recredentialing and Screening / Enrollment, Title 42, CFR, Section 455, and as described Sections III.A. and III.B. of this Policy.

~~J.~~K. CalOptima shall ~~Recredential~~recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

~~K.~~L. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall ~~provide evidence of monthly review of the Medical Board of California and Office of Inspector General (OIG) exclusion, or suspension, list~~monitor various state, federal, boards, agencies and databanks for adverse activities in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Activities.

~~L.~~M. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify, in writing, such Practitioner within thirty (30) calendar days of the date of the decision of the reason(s) for ~~its decision~~the denial.

~~M.~~N. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima's responsibilities.

~~N.~~O. CalOptima shall not discriminate against a Practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

~~O.~~P. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

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~~P.~~Q. CalOptima shall monitor and prevent discriminatory Credentialing decisions as ~~follows:~~provided in this Policy.

~~1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure Practitioners are not discriminated against at least annually;~~

~~2. Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination, including a review by the CPRC of quarterly reports of complaints, including discrimination at least annually;~~

~~3. Maintaining a heterogeneous Credentialing committee membership; and~~

~~4. Requiring those responsible for Credentialing and Recredentialing decisions to sign a statement affirming that they do not discriminate when making decisions.~~

~~Q.~~R. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

~~R.~~S. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

~~S.~~T. CalOptima shall ~~render a~~ ensure that information collected on the application is no more than six (6) months old from the date of the final decision ~~within one hundred eighty (180) calendar days from the date of licensure verification.~~made by the credentialing committee.

6. If CalOptima is unable to render a decision within ~~one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing, or Recredentialing process~~six months, the application shall be considered expired, and Credentialing will re-initialize.

~~T.~~U. Except as provided in CalOptima Policy GG.1608Δ: Full Scope Site Reviews, CalOptima does not delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health Network. CalOptima assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

~~U.~~V. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima.

   a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

   b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in CalOptima Policy GG.1643Δ: Minimum Physician Standards and CalOptima will verify that the Physician Practitioner meets the minimum standards as provided in ~~this~~that Policy.

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c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima that attests to:

i. Any work history gap that exceeds six (6) months, including written clarification;

ii. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

iii. Lack of present illegal drug use that impairs current ability to practice;

iv. History of ~~any loss of license and history of felony~~criminal convictions;

v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

vi. Current malpractice insurance coverage; and

vii. The correctness and completeness of the application;

d. All ~~credentialing~~Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

e. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

f. CalOptima shall return an incomplete application to a Practitioner, and such incomplete application will not be processed until the Practitioner submits all the required information.

g. An NMP, other than a PA, who does not have an individual relationship with CalOptima, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Provider.

h. A PA who does not have an individual relationship with CalOptima, and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Provider; or

ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

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2. Upon receipt of a complete Credentialing application, CalOptima shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

   a. A current, valid California license to practice in effect at the time of the Credentialing decision;

   b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians; and

   c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements and if applicable, completion of residency, and specialty training.

3. CalOptima shall also collect and verify the following information from each Provider as applicable~~,~~ but need not verify this information through a primary source. This information includes, but is not limited to:

   a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

   b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;

   c. Any alternative admitting arrangements must be documented in the Credentialing file;

   d. A valid DEA, or Controlled Dangerous Substances (CDS), certificate obtained through confirmation by National Technical Information Service (NTIS), if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

   e. A valid National Provider Identifier (NPI) number;

   f. Current malpractice insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision;

   g. Practitioner information entered in the National Practitioner Data Bank (NPDB), if applicable;

   h. No exclusion, preclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the Credentialing decision;

   i. A review of any Grievances, or quality~~,~~ cases, filed against a Practitioner in the last five (5) years;

   j. No exclusion or preclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years that supports a mandatory

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exclusion or preclusion under the Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect, or ~~Abuse~~abuse, of patients in connection with the delivery of a health care item, or service;

iii. A felony conviction related to health care ~~Fraud~~fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

k. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner;

l. History of state sanctions, restrictions on licensure or limitations on scope of practice;

m. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;

n. Full or provisional California Children's Services (CCS) ~~-~~paneled approval status, with a current active panel status;

o. Current IRS Form W-9;

p. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews; ~~and~~

q. Active enrollment status with Medi-Cal, as required~~.~~; and

r. ~~Active enrollment status with~~Absence from the Medicare Preclusion List for OneCare~~, or~~ and OneCare Connect ~~as required.~~Practitioners.

B. Practitioner Recredentialing

1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

a. Collect and verify, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.A of this Policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the Practitioner; and

b. Incorporate the following data in the decision-making process~~:~~, which shall have been reviewed no more than one hundred eighty (180) calendar days before the Recredentialing decision is made.

i. Member Grievances and ~~appeals~~Appeals, including number and type during the past three (3) years;

ii. Information from quality review activities;

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iii. Board Certification, if applicable;

iv. Member satisfaction, if applicable;

v. Medical Record Reviews, if applicable;

vi. ~~Facility Site Review (~~FSR~~)~~ results and ~~Physical Accessibility Review Survey (~~PARS~~)~~ results, if applicable; and

vii. Compliance with the terms of the Practitioner's contract.

c. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) Full Scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

4. If CalOptima terminates a Practitioner during the Recredentialing process for administrative reasons (i.e., the Practitioner failed to provide complete credentialing information) and not for quality reasons (i.e., medical disciplinary cause or reason), it may reinstate the Practitioner within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial Credentialing of such Practitioner.

C. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner rights ~~attached to~~included in the ~~CPPA as~~ Addendum A, ~~describing of~~ the ~~following~~credentialing application, as follows:

a. Right to review information

i. Practitioners will be notified of their right to review information CalOptima has obtained to evaluate their credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure.

b. Right to correct erroneous information

i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

ii. All Practitioners have the right to correct erroneous information, as follows:

a) The Practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

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b) Requests for correction of erroneous information must be submitted by certified mail on the Practitioner's letterhead with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

c) All submissions will be mailed to CalOptima's Quality Improvement Department using the following address:

Attention: Quality Improvement Department – Credentialing
CalOptima
505 City Parkway West
Orange, CA 92868

iii. CalOptima is not required to reveal the source of information, if the information is not obtained to meet CalOptima's Credentialing verification requirements, or if federal or state law prohibits disclosure.

2. Documentation of receipt of corrections

a. A ~~practitioner~~Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima's receipt of the identified erroneous information.

3. Right to be notified of application status

a. Practitioners may receive the status of their Credentialing~~,~~ or Recredentialing~~,~~ application, upon request.

b. Practitioners may request to review non-privileged information obtained from outside sources (e.g., malpractice insurance carriers and licensing boards).

c. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing and Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network~~,~~ and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files~~,~~ and determining the Practitioner's participation in CalOptima programs.

3. Completed Credentialing and Recredentialing files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than $25,000 paid by,

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or on behalf of, the Practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review

i. A clean file shall be considered approved and effective on the date that the CMO or his or her physician Designee review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

ii. Approved, clean file lists shall be presented at the CPRC and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include ~~a history of~~more than one (1) malpractice claim~~(s)~~ that resulted in settlements or judgments ~~paid by, or on behalf of, the Practitioner, identification of Practitioner, or OIG exclusion list, Medi-Cal Suspended and Ineligible Provider List~~greater than $25,000, or NPDB query identifying Medical Board investigations, or other actions.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

ii. CPRC ~~minutes~~ shall ~~reflect~~give thoughtful consideration ~~of~~to the information presented in the credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conference, but may not be conducted through e-mail.

4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process~~,~~ and shall be verified prior to making a Credentialing decision.

a. The Quality Improvement Department shall send the Practitioner a decision letter, within thirty (30) calendar days of the decision:

i. Acceptance;

ii. Acceptance with ~~Restrictions~~restrictions along with Appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; or

iii. Denial of the application along with Appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing~~,~~ or Recredentialing process, the application shall be considered expired.

E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

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1. Monitoring~~:~~

   a. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

   b. Review Practitioner complaints to determine if there are complaints alleging discrimination.

   c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

2. Prevention~~:~~

   a. The QI Department shall maintain a heterogeneous credentialing committee~~,~~ and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. This Provider profile shall be generated from the ~~credentialing~~Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (i.e., education, training, Board Certification and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online provider directory.

IV. ATTACHMENT(S)

A. California Participating Physician Application (CPPA)
B. CalOptima Primary Source Verification Table
C. Council for Affordable Quality Healthcare Provider Application (CAQH)
D. HIV/AIDS Specialist Designation
E. Attestation Questions
F. Addendum A Practitioner Rights

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~C.~~D. CalOptima PACE Program Agreements
~~D.~~E. CalOptima Contract for Health Care Services
~~E.~~F. ~~2017~~ NCQA Standards and Guidelines
~~F.~~G. CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access
H. CalOptima Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice
~~G.~~I. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
~~H.~~J. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
~~I.~~K. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
~~J.~~L. CalOptima Policy GG.1608Δ: Full Scope Site Reviews

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~~K.~~M. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
N. CalOptima Policy GG.1619: Delegation Oversight
~~L.~~O. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
~~M.~~P. CalOptima Policy GG.1643Δ: Minimum Physician Standards
~~N.~~Q. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of a Healthcare Delivery Organization (HDO)
~~O.~~R. CalOptima Policy HH.1101: CalOptima Provider ~~Compliant~~Complaint
~~P.~~S. CalOptima Policy MA.9006: Provider Complaint Process
~~Q.A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~R.~~T. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit
U. Department of Health Care Services All Plan Letter (APL) ~~17-019~~19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
V. Department of Health Care Services All Plan Letter (APL) 18-~~011~~023: California Children's Services Whole Child Model Program
~~S.~~U. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
~~T.~~V. Title ~~45~~42, Code of Federal Regulations, §455, Subpart E
~~U.~~W. Title 42, United States Code, §1320a-7(a)
~~V.~~X. Title XVIII and XIV of the Social Security Act
~~W.~~Y. California Business and Professions Code, §805 and §§3500-3502.3
~~X.~~Z. California Evidence Code, §1157
AA. Medicare Managed Care Manual, Chapter 6: Relationships with Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/28/2015	Department of Health Care Services (DHCS)
09/20/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1996	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	02/01/1998	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	01/01/1999	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	08/01/2000	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	02/01/2001	GG.1609	Credentialing and Recredentialing	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2006	MA.7009	Credentialing and Recredentialing	OneCare
Revised	07/01/2007	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	07/01/2009	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2011	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	03/01/2012	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2013	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	06/01/2014	GG.1609	Credentialing and Recredentialing	Medi-Cal
Retired	02/01/2015	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Retired	03/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Revised	03/01/2015	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Retired	06/01/2017	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Effective	06/01/2017	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
~~Abuse~~	~~Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.~~
Appeal	A request by the member or the member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
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 persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
~~Board Certification/Certified~~	~~Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.~~
Continuity of Care	Services provided to a member rendered by an out-of-network provider with whom the member has pre-existing provider relationship.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing and Peer Review Committee (CPRC)	~~Peer review body who reviews all recommendations and decisions regarding credentialing and Recredentialing~~The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization	~~An~~For purposes of this policy, an organization that collects and verifies credentialing information.

For 2020 10/1 BOD Review Only

Term	Definition
~~Delegation Services Agreement~~Delegate	~~Mutually agreed upon document, signed by both parties, which includes, without limit:~~ ~~1. CalOptima responsibilities;~~ ~~2. Duration of the agreement;~~ ~~3. Termination of the agreement;~~ ~~4. Delegated Entity responsibilities and Delegated Services;~~ ~~5. Types and frequency of reporting to the Delegated Entity;~~ ~~6. Process by which the CalOptima evaluates the Delegated Entity's performance (Performance Measurements);~~ ~~7. Use of confidential CalOptima information including member Protected Health Information (PHI) by the Delegated Entity; and~~ ~~Remedies available to the CalOptima if the Delegated Entity does not fulfill its obligations.~~An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement 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 health and/or administrative services.
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.
~~Fraud~~Federally Qualified Health Center (FQHC)	~~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).~~A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume specialist physician offices.
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Grievance	~~An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or appeal made by a member.~~A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the MCP to make an authorization decision. Also, a Complaint from a Member related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code Section 14450 and California Health and Safety Code Section 1368 and 1368.1.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to members assigned to that health network.

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Term	Definition
Long Term Support Services (LTSS) Provider	~~A~~For purposes of this policy, a licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to Section 3502 of the Business and Professions Code and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Provider (PCP).
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.

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Term	Definition
Specialty Care	For purposes of this policy, specialty care given to members by referral by other than a Primary Care Provider (PCP).
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
~~Waste~~	~~The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.~~

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Policy:	GG.1650Δ
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	06/01/2017
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 2020 1001 BOD Review Only

I. PURPOSE

This policy defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select Practitioners to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, Section 422.204(a) and other applicable laws, regulations, and guidance.

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network or other Delegate in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities. Delegated activities may include but are not limited to: Credentialing decisions, Credentialing verification, monitoring of sanctions, and processing of Credentialing applications.

1. A Health Network or Delegate shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO) or his or her physician Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities shall include but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving provider files, and ensuring credentialing policies are adhered to.

D. The CalOptima CPRC shall be responsible for reviewing a Practitioner's Credentialing information and determining such Practitioner's participation in CalOptima.

E. CalOptima shall credential and recredential the following Practitioners as provided in this Policy: Physicians, Non-Physicians Medical Practitioners, Behavioral Health Practitioners, Substance Use Disorder (SUD) Practitioners, and Long Term Services and Supports (LTSS) Practitioners that provide care to CalOptima program Members, and are:

1. Licensed, certified, or registered by the state of California to practice independently;

2. Contracted with CalOptima to provide care under CalOptima's programs (including those Practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary and Specialty Care services); and

3. Who provide care to Members under the organization's medical benefits.

F. Credentialing and recredentialing shall apply to Practitioners meeting the criteria in Section II.E. of this Policy, regardless of whether they provide care:

1. In individual or group practices;

2. In facilities; or

3. Through telemedicine/telehealth i.e., virtual care visit.

G. CalOptima shall credential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and do not have an independent relationship with CalOptima including:

1. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP; or

2. NMPs who provide services as part of an Organized health Care System that is credentialed with CalOptima and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

3. NMPs who are not PAs and who provide services under the employment agreement of a credentialed Provider.

H. An NMP shall notify CalOptima immediately if the supervising Physician Practitioner no longer meets the CalOptima Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or employment with the entity or Organized Health System.

I. CalOptima does not credential or recredential:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provide care for a Member only as a result of the Member being directed to the hospital, or inpatient, setting;

2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates Utilization Management (UM) functions (Credentialing of Pharmacies and its professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access);

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4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima; and

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer).

J. CalOptima shall ensure that any provider for whose provider type has an enrollment pathway with Department of Health Care Services (DHCS) is enrolled with DHCS as a provider in accordance with DHCS All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment, Title 42, CFR, Section 455, and as described Sections III.A. and III.B. of this Policy.

K. CalOptima shall recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

L. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall monitor various state, federal, boards, agencies and databanks for adverse activities in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Activities.

M. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify, in writing, such Practitioner within thirty (30) calendar days of the date of the decision of the reason(s) for the denial.

N. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima's responsibilities.

O. CalOptima shall not discriminate against a Practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

P. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

Q. CalOptima shall monitor and prevent discriminatory Credentialing decisions as provided in this Policy.

R. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

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S. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

T. CalOptima shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the credentialing committee.

6. If CalOptima is unable to render a decision within six months, the application shall be considered expired, and Credentialing will re-initialize.

U. Except as provided in CalOptima Policy GG.1608Δ: Full Scope Site Reviews, CalOptima does not delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health Network. CalOptima assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

V. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima.

a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in CalOptima Policy GG.1643Δ: Minimum Physician Standards and CalOptima will verify that the Physician Practitioner meets the minimum standards as provided in that Policy.

c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima that attests to:

i. Any work history gap that exceeds six (6) months, including written clarification;

ii. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

iii. Lack of present illegal drug use that impairs current ability to practice;

iv. History of criminal convictions;

v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

vi. Current malpractice insurance coverage; and

vii. The correctness and completeness of the application;

d. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

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e. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

f. CalOptima shall return an incomplete application to a Practitioner, and such incomplete application will not be processed until the Practitioner submits all the required information.

g. An NMP, other than a PA, who does not have an individual relationship with CalOptima, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Provider.

h. A PA who does not have an individual relationship with CalOptima, and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Provider; or

ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision;

b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians; and

c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements and if applicable, completion of residency, and specialty training.

3. CalOptima shall also collect and verify the following information from each Provider as applicable but need not verify this information through a primary source. This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

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b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;

c. Any alternative admitting arrangements must be documented in the Credentialing file;

d. A valid DEA, or Controlled Dangerous Substances (CDS), certificate obtained through confirmation by National Technical Information Service (NTIS), if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

e. A valid National Provider Identifier (NPI) number;

f. Current malpractice insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision;

g. Practitioner information entered in the National Practitioner Data Bank (NPDB), if applicable;

h. No exclusion, preclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the Credentialing decision;

i. A review of any Grievances, or quality cases, filed against a Practitioner in the last five (5) years;

j. No exclusion or preclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion or preclusion under the Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

   i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

   ii. A felony conviction related to neglect, or abuse, of patients in connection with the delivery of a health care item, or service;

   iii. A felony conviction related to health care fraud; or

   iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

k. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner;

l. History of state sanctions, restrictions on licensure or limitations on scope of practice;

m. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;

n. Full or provisional California Children's Services (CCS)-paneled approval status, with a current active panel status;

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o. Current IRS Form W-9;

p. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews;

q. Active enrollment status with Medi-Cal, as required; and

r. Absence from the Medicare Preclusion List for OneCare and OneCare Connect Practitioners.

B. Practitioner Recredentialing

1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

a. Collect and verify, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.A of this Policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the Practitioner; and

b. Incorporate the following data in the decision-making process, which shall have been reviewed no more than one hundred eighty (180) calendar days before the Recredentialing decision is made.

i. Member Grievances and Appeals, including number and type during the past three (3) years;

ii. Information from quality review activities;

iii. Board Certification, if applicable;

iv. Member satisfaction, if applicable;

v. Medical Record Reviews, if applicable;

vi. FSR results and PARS results, if applicable; and

vii. Compliance with the terms of the Practitioner's contract.

c. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) Full Scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

4. If CalOptima terminates a Practitioner during the Recredentialing process for administrative reasons (i.e., the Practitioner failed to provide complete credentialing information) and not for quality reasons (i.e., medical disciplinary cause or reason), it may reinstate the Practitioner

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within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial Credentialing of such Practitioner.

C. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner rights included in the Addendum A of the credentialing application, as follows:

   a. Right to review information

      i. Practitioners will be notified of their right to review information CalOptima has obtained to evaluate their credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure.

   b. Right to correct erroneous information

      i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

      ii. All Practitioners have the right to correct erroneous information, as follows:

         a) The Practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

         b) Requests for correction of erroneous information must be submitted by certified mail on the Practitioner's letterhead with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

         c) All submissions will be mailed to CalOptima's Quality Improvement Department using the following address:

            Attention: Quality Improvement Department – Credentialing
            CalOptima
            505 City Parkway West
            Orange, CA 92868

      iii. CalOptima is not required to reveal the source of information, if the information is not obtained to meet CalOptima's Credentialing verification requirements, or if federal or state law prohibits disclosure.

2. Documentation of receipt of corrections

   a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima's receipt of the identified erroneous information.

3. Right to be notified of application status

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a. Practitioners may receive the status of their Credentialing or Recredentialing application, upon request.

b. Practitioners may request to review non-privileged information obtained from outside sources (e.g., malpractice insurance carriers and licensing boards).

c. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing and Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files and determining the Practitioner's participation in CalOptima programs.

3. Completed Credentialing and Recredentialing files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than $25,000 paid by, or on behalf of, the Practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review

i. A clean file shall be considered approved and effective on the date that the CMO or his or her physician Designee review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

ii. Approved, clean file lists shall be presented at the CPRC and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include more than one (1) malpractice claim that resulted in settlements or judgments greater than $25,000, or NPDB query identifying Medical Board investigations, or other actions.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

ii. CPRC shall give thoughtful consideration to the information presented in the credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conference, but may not be conducted through e-mail.

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4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process and shall be verified prior to making a Credentialing decision.

    a. The Quality Improvement Department shall send the Practitioner a decision letter, within thirty (30) calendar days of the decision:

        i. Acceptance;

        ii. Acceptance with restrictions along with Appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; or

        iii. Denial of the application along with Appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

    b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

        i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing or Recredentialing process, the application shall be considered expired.

E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

    1. Monitoring

        a. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

        b. Review Practitioner complaints to determine if there are complaints alleging discrimination.

        c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

    2. Prevention

        a. The QI Department shall maintain a heterogeneous credentialing committee and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. This Provider profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (i.e., education, training, Board Certification and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online provider directory.

IV. ATTACHMENT(S)

For 20201001 BOD Review Only

A. California Participating Physician Application (CPPA)
B. CalOptima Primary Source Verification Table
C. Council for Affordable Quality Healthcare Provider Application (CAQH)
D. HIV/AIDS Specialist Designation
E. Attestation Questions
F. Addendum A Practitioner Rights

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 PACE Program Agreements
E. CalOptima Contract for Health Care Services
F. NCQA Standards and Guidelines
G. CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access
H. CalOptima Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice
I. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
J. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
K. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
L. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
M. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
N. CalOptima Policy GG.1619: Delegation Oversight
O. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
P. CalOptima Policy GG.1643Δ: Minimum Physician Standards
Q. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of a Healthcare Delivery Organization (HDO)
R. CalOptima Policy HH.1101: CalOptima Provider Complaint
S. CalOptima Policy MA.9006: Provider Complaint Process
T. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit
U. Department of Health Care Services All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
V. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program
U. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
V. Title 42, Code of Federal Regulations, §455, Subpart E
W. Title 42, United States Code, §1320a-7(a)
X. Title XVIII and XIV of the Social Security Act
Y. California Business and Professions Code, §805 and §§3500-3502.3
Z. California Evidence Code, §1157
AA. Medicare Managed Care Manual, Chapter 6: Relationships with Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/28/2015	Department of Health Care Services (DHCS)
09/20/2018	Department of Health Care Services (DHCS)

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VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1996	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	02/01/1998	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	01/01/1999	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	08/01/2000	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	02/01/2001	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	01/01/2006	MA.7009	Credentialing and Recredentialing	OneCare
Revised	07/01/2007	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	07/01/2009	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2011	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	03/01/2012	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2013	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	06/01/2014	GG.1609	Credentialing and Recredentialing	Medi-Cal
Retired	02/01/2015	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Retired	03/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Revised	03/01/2015	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Retired	06/01/2017	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Effective	06/01/2017	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/06/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	A request by the member or the member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
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 persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae 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.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization	For purposes of this policy, an organization that collects and verifies credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement 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 health and/or administrative services.
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.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.

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Term	Definition
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume specialist physician offices.
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Grievance	A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the MCP to make an authorization decision. Also, a Complaint from a Member related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code Section 14450 and California Health and Safety Code Section 1368 and 1368.1.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to members assigned to that health network.
Long Term Support Services (LTSS) Provider	For purposes of this policy, a licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.

For 2020 COI ROD Review Only

Term	Definition
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to Section 3502 of the Business and Professions Code and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Provider (PCP).
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to members by referral by other than a Primary Care Provider (PCP).
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.

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California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. Identifying Information

Last Name: First Name: Middle:

Is there any other name under which you have been known? Name(s):

Home Mailing Address:

City: State: Zip Code: -

Home Phone Number: ( ) - Fax Number: ( ) - Cell Number: ( ) - Pager Number: ( ) -

Practitioner Email: Citizenship (If not a U.S. citizen, please provide a copy of Alien Registration Card):

Birth Date: Social Security Number: - -

Birth Place: Gender Male Female

Driver's License State/Number: Race/Ethnicity (optional):

Your intent is to serve as a(n):

Primary Care Provider Specialist Urgent Care Hospitalist Hospital Based

Specialty:

Subspecialties:

III. Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Primary Office Address:

City: State: Zip Code: -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number: ( ) -

Office Administrator/Manager Email: Office Administrator/Manager Fax Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

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III. Practice Information (Continued)

Please identify the physical accessibility of this office. ○ Basic ○ Limited ○ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

please type the working days and the working hours

Primary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

Secondary Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Secondary Office Address:

City: State: Zip Code: -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: Office Administrator/Manager Fax Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

Please identify the physical accessibility of this office. ○ Basic ○ Limited ○ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Secondary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

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Tertiary Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Tertiary Office Address:

City: State: Zip Code: -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number: ( ) -

Office Administrator/Manager Email: Office Administrator/Manager Fax Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Tertiary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

Mailing Address

Which of your practices is your primary mailing address? ◯ Primary ◯ Secondary ◯ Tertiary ◯ Other

If your mailing address is different from your practice address, please provide it:

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IV. Billing Information

Which of your practices handles your billing? ◯ Primary ◯ Secondary ◯ Tertiary If none, please provide billing information:

Billing Company

Billing Company Mailing Address:

City: State: Zip Code: -

Contact Person: Telephone Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

V. Practice Description

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologist, etc.)? ◯ Yes ◯ No
If so, please list:

Name	Type of Provider	License Number

Physician Assistant Supervisor Name: License Number:

Do you personally employ any physicians (do not include physicians who are employed by the medical group)? ◯ Yes ◯ No
If so, please list:

Name	California Medical License Number	Primary/Secondary/Tertiary Practice
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you perform that are not typically associated with your specialty:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you do **not** perform that are typically associated with your specialty:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Is your practice limited to certain ages? ◯ Yes ◯ No If yes, specify limitation:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Coverage of Practice

List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering Service Company

Answering Service Mailing Address:

City: State: Zip Code: - Email:

Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

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VI. Education, Training and Experience

Medical/Professional Education

Medical School/Professional: | Degree Received: | Graduation Date:

Mailing Address: | Website (if applicable):

City: | State: | Zip Code: - | Registrar's Phone Number: ( ) -

Internship/PGY-1

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Internship: | From (mm/yyyy): | To (mm/yyyy):

Did you successfully complete the program? ◯ Yes ◯ No (If No, please explain on a separate sheet.)

Residencies/Fellowships

Include residencies, fellowships, and postgraduate education in chronological order. Use a separate sheet if necessary.

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ☒ No (Please explain on a separate sheet.) | To(mm/yy):

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

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VII. Medical Licensure & Certifications

California State Medical License Number	Issue Date	Expiration Date

Drug Enforcement Agency (DEA) Registration Number	Schedules	Expiration Date

Controlled Dangerous Substances Certificate (CDS) (if applicable)	Expiration Date

ECFMG Number (applicable to foreign medical graduates)	Issue Date

Individual National Physician Identifier (NPI)	Medi-Cal/Medicaid Number	Individual Medicare PTAN Number

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

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Board Certification(s) (Continued)

Have you applied for board certification other than those indicated on the prior page? ◯ Yes ◯ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification below or in a separate sheet.

Specialty:

Board Name:

Exam Date:

Describe here:

VIII. Current Hospital and Other Institutional Affiliations

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

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A. Current Affiliations

Hospital Name: | Department Name : | Status (active, provisional, courtesy, temporary, etc.):

Primary Hospital Address:

City: | State: | Zip Code: - | From (mm/yy):

Medical Staff Phone: ( ) - | Medical Staff Fax: ( ) - | To (mm/yy):

Hospital Name: | Department Name : | Status (active, provisional, courtesy, temporary, etc.):

Secondary Hospital Address:

City: | State: | Zip Code: - | From (mm/yy):

Medical Staff Phone: ( ) - | Medical Staff Fax: ( ) - | To (mm/yy):

Hospital Name: | Department Name : | Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: | State: | Zip Code: - | From (mm/yy):

Medical Staff Phone: ( ) - | Medical Staff Fax: ( ) - | To (mm/yy):

Hospital Name: | Department Name : | Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: | State: | Zip Code: - | From (mm/yy):

Medical Staff Phone: ( ) - | Medical Staff Fax: ( ) - | To (mm/yy):

A. Current Affiliations (continued)

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):

B. Previous Hospital and Other Institution Affiliations

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

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IX. Peer References

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference: Specialty:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Email Address:

Name of Reference: Specialty:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Email Address:

Name of Reference: Specialty:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Email Address:

X. Work History

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. Curriculum vitae are not sufficient. Please explain any gaps on a separate page.

Current Practice: Contact Name:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - From (mm/yy): To (mm/yy):

For 20201001 BOD Review Only

XI. Professional Liability

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier: Policy Number:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

For 20201001 BOD Review Only

XII. Professional and Practice Services

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? Yes No

What type of anesthesia do you provide in your group/office?

Local Regional Conscious Sedation General None Other (please specify)

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver.

Federal Tax ID: Type of Service Provided: Do you have a CLIA certificate? Yes No

Billing Name: Do you have a CLIA waiver? Yes No

CLIA Certificate Number: CLIA Certificate Expiration Date:

XII. Professional and Practice Services (continued)

Have you or your office received any of the following accreditations, certificates or licensures?

- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- ☐ Medicare Certification
- ☐ The Medical Quality Commission (TMQC)
- ☐ Child Health and Disability Prevention Program (CHDP)
- ☐ Comprehensive Perinatal Services Program (CPSP)
- ☐ California Children Services (CCS)
- ☐ Family Planning
- ☐ Other

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant. Use the drop-down list to select your membership status.

Organization Name	Membership Status

Do you participate in electronic data interchange (EDI)? ◯ Yes ◯ No If so, which Network?

Do you use a practice management system/software? ◯ Yes ◯ No If so, which one?

For 20201001 BOD Review Only

Continue to the Next Page for HIV/AIDS Specialist Designation

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine. **OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. **OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**
3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

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Continue to the Next Page for Attestation Questions

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ◯ Yes ◯ No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ◯ Yes ◯ No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs), or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ◯ Yes ◯ No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ◯ Yes ◯ No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ◯ Yes ◯ No

6. Have you ever been denied certification/recertification by a specialty board? ◯ Yes ◯ No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ◯ Yes ◯ No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ◯ Yes ◯ No
   b. Are any such actions pending? ◯ Yes ◯ No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If **YES**, please complete Addendum B. ◯ Yes ◯ No

10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If **YES**, please complete Addendum B. ◯ Yes ◯ No

11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ◯ Yes ◯ No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **YES**, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ◯ Yes ◯ No

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Continue to the Next Page for Additional Attestation Questions

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. ◯ Yes ◯ No

    If **YES**, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ◯ Yes ◯ No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ◯ Yes ◯ No

15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ◯ Yes ◯ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable) | **PRINTED NAME** | **DATE**

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Continue to the Next Page for Information Release/ Acknowledgements

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

For 20201001 IGD Review Only

APPLICANT SIGNATURE (Stamp is Not Acceptable) **PRINTED NAME** **DATE**

Addenda Submitting :

☐ Addendum B: Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

The CPPA has been completed. Please be sure you have signed the last two pages (pages 15 and 16) before submission.

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.

The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of your application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correct will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

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Healthcare Organization's Credentialing Department Address:

Address:	505 City Parkway West				
City:	Orange	ST:	CA	Zip:	92868

APPLICANT SIGNATURE (Stamp is Not Acceptable) ✖

PRINTED NAME ✖

DATE ✖

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise conclude professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/ settled claims to report (and sign below to attest).*

I. Practioner Identifying Information

Last Name: _____ First Name: _____ Middle: _____

II. Case Information

Patient's Name: _____ Patient Gender ◯ Male ◯ Female Patient DOB: _____

City, County, State where lawsuit filed: _____ Court Case number, if known: _____ Date of alleged incident serving as basis for the lawsuit/ arbitration: _____ Date suit filed: _____

Location of incident:
☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify) _____

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.) _____

Allegation

_____

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ◯ Yes ◯ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

_____

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name: _____ Telephone Number: ( ) - Fax Number: ( ) -

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III. Status of Lawsuit/Arbitration (check one)

- ☐ Lawsuit/arbitration still ongoing, unresolved.
- ☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____
- ☐ Judgment rendered and I was found not liable.
- ☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____
- ☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

For 20201001 BOD Review Only

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE (Stamp is Not Acceptable) ✖ **PRINTED NAME** ✖ **DATE** ✖

CalOptima Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of ~~Documentation~~Verification
MD – Medical Board of California	https://search.dca.ca.gov/	~~Full print out indicating "data current as of" and the accessed date at bottom of the print out~~Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DO- Osteopathic Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating "data current as of" and the accessed date at bottom of the print out~~
DC- California Board of Chiropractic	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating "data current as of" and the accessed date at bottom of the print out~~
DDS- Dental Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating "data current as of" and the accessed date at bottom of the print out~~
DPM- California Board of Podiatric Medicine	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating "data current as of" and the accessed date at bottom of the print out~~

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Revised 11/15/2018, 02/01/2019,3/15/19, 4/23/19,8/26/19,3/13/20,3/12/20

CalOptima Primary Source Verification Table

California Board of Psychology	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating "data current as of" and the accessed date at bottom of the print out~~
California Board of Behavioral Sciences	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating "data current as of" and the accessed date at bottom of the print out~~
Department of Consumer Affairs Acupuncture Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating "data current as of" and the accessed date at bottom of the print out~~
Department of Consumer Affairs CA State Board of Optometry	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating "data current as of" and the accessed date at bottom of the print out~~
California Board of Registered Nursing	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating "data current as of" and the accessed date at bottom of the print out~~
California Department of Consumer Affairs; Physician Assistant Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating~~

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		~~"data current as of" and the accessed date at bottom of the print out~~
Physical Therapy Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs California Board of Occupational Therapy	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer affairs Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

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Primary Source Verification – DEA

DEA	Source of Verification	Method of ~~Documentation~~Verification
DEA	National Technical Information System-NTIS https://deanumber.com/default.aspx?relID=33637	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Full print out indicating "data current as of"~~
	https://www.deadiversion.usdoj.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out~~
	AMA/AOIA Physician Master File	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out~~
	Copy of current DEA certificate	Visual inspection of certificate and stored in Credentialing database./~~print out~~

CalOptima Primary Source Verification Table

Primary Source Verification – Board Certification

Certification	Source of Verification	Method of Verification~~Documentation~~
Board Certification	https://www.boardcertifieddocs.com/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out~~
	https://www.aoaprofiles.org/ American Board of Podiatric Surgery	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out~~
	American Board of Medical Specialties https://www.abms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out~~
	American Osteopathic Association (AOA) https://osteopathic.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out~~
	https://www.abpp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated
	American Board of Foot and Ankle Surgery (ABFAS) https://www.abfas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out~~
	American Board of Oral and Maxillofacial Surgery (ABOMS) https://www.aboms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out~~

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CalOptima Primary Source Verification Table

Primary Source Verification – Education & Training

Education	Source of Verification	Method of ~~Documentation~~Verification
Education & Training	Board certification by ABMS or AOIA in practicing specialty	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out certificate~~
	AMA Physician Master File https://www.ama-assn.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out of AMA with education "verified" not "being verified" or "being re-verified"; Print out~~
	AOIA Official Osteopathic Physician Profile Report https://www.aoaprofiles.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~AOA Profile~~
	Contact the training institution to verify the highest level of training; or State Licensing Agency, as applicable.	Letter from institution is reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~stating that practitioner successfully completed the training in good standing or provide an explanation if the practitioner was ever disciplined.~~
	National Student Clearing House http://nscverifications.org/welcome-to-verification-serives/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~The National Student Clearing house is the trusted source for education verification offering a~~

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		~~nationwide collection of enrollment and degree data. Print out verification~~

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CalOptima Primary Source Verification Table

Primary Source Verification – Malpractice History

Malpractice Information	Source of Verification	Method of Verification~~Documentation~~
Malpractice History	NPDB https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out of report~~

Primary Source Verification – ~~Medicare/Medicaid~~ Sanctions

Sanction Information	Source of Verification	Method of ~~Documentation~~Verification
State & Federal Sanctions Sources	National Practitioner Data Bank- NPDB https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Print out of report~~
	System for Award Management-SAM https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Information entered in Credentialing Data Base and print out included in the credentialing packet~~
	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Information entered in Credentialing Data Base and print out included in the credentialing packet~~
	Medi-Cal Suspended & Ineligible List https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Information entered in Credentialing Data Base and print out included in the credentialing packet~~

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	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~Information entered in Credentialing Data Base and print out included in the credentialing packet~~
Other Sanction Sources	AMA Physician Master File	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~In credentialing file (if used for verification of another element)~~
	AOIA Physician Profile report	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~In credentialing file~~

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~~Primary Source Verification – Medicare Opt-Out~~

~~Opt-Out Information~~	~~Source of Verification~~	~~Method of Documentation~~
~~Medicare Opt-Out~~	~~https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z~~	~~Information entered in Credentialing Data Base and print out included in the credentialing packetN/A~~

CalOptima Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Verification
MD – Medical Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DO- Osteopathic Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DC- California Board of Chiropractic	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DDS- Dental Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DPM- California Board of Podiatric Medicine	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Psychology	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Behavioral Sciences	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs Acupuncture Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

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CalOptima Primary Source Verification Table

Department of Consumer Affairs CA State Board of Optometry	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Registered Nursing	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Department of Consumer Affairs; Physician Assistant Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Physical Therapy Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs California Board of Occupational Therapy	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer affairs Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

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Primary Source Verification – DEA

DEA	Source of Verification	Method of Verification
DEA	National Technical Information System-NTIS https://deanumber.com/default.aspx?relID=33637	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	https://www.deadiversion.usdoj.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are

		electronically tracked and dated.
	AMA/AOIA Physician Master File	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Copy of current DEA certificate	Visual inspection of certificate and stored in Credentialing database.

Primary Source Verification – Board Certification

Certification	Source of Verification	Method of Verification
Board Certification	https://www.boardcertifieddocs.com/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	https://www.aoaprofiles.org/ American Board of Podiatric Surgery	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Medical Specialties https://www.abms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Osteopathic Association (AOA) https://osteopathic.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	https://www.abpp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated
	American Board of Foot and Ankle Surgery (ABFAS) https://www.abfas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

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	American Board of Oral and Maxillofacial Surgery (ABOMS) https://www.aboms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – Education & Training

Education	Source of Verification	Method of Verification
Education & Training	Board certification by ABMS or AOIA in practicing specialty	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AMA Physician Master File https://www.ama-assn.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Official Osteopathic Physician Profile Report https://www.aoaprofiles.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Contact the training institution to verify the highest level of training; or State Licensing Agency, as applicable.	Letter from institution is reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Student Clearing House http://nscverifications.org/welcome-to-verification-serives/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

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CalOptima Primary Source Verification Table

Primary Source Verification – Malpractice History

Malpractice Information	Source of Verification	Method of Verification
Malpractice History	NPDB https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification –Sanctions

Sanction Information	Source of Verification	Method of Verification
State & Federal Sanctions Sources	National Practitioner Data Bank- NPDB https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	System for Award Management-SAM https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Medi-Cal Suspended & Ineligible List https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Other Sanction Sources	AMA Physician Master File	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

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CalOptima Primary Source Verification Table

	AOIA Physician Profile report	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

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Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 | CORRECT MARK: X | INCORRECT MARKS: ≠ ✓ •

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 Personal Information and Professional IDs

Provider Type

Code list is found on page 36. Enter the associated 3-digit code in the space provided.*

YES NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME* SUFFIX (JR, III)

FIRST NAME* MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME SUFFIX (JR, III)

OTHER FIRST NAME OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (M M D D Y Y Y Y) DATE STOPPED USING OTHER NAME (M M D D Y Y Y Y)

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE DATE OF BIRTH* (M M D D Y Y Y Y)

CITY OF BIRTH STATE OF BIRTH COUNTRY OF BIRTH

SSN* - -

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE

Home Address

NUMBER STREET APT NUMBER

CITY STATE ZIP CODE

TELEPHONE - -

NOTE: CAQH will use this method for application follow-up.

E-MAIL

FAX - -

PREFERRED METHOD OF CONTACT* E-MAIL FAX

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 — Personal Information and Professional IDs (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

Non-licensed professionals should enter certification/ registration number in the space provided for license number.

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Other ID Numbers

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

ARE YOU A PARTICIPATING MEDICARE PROVIDER?* YES NO

MEDICARE NUMBER

UPIN

ARE YOU A PARTICIPATING MEDICAID PROVIDER?* YES NO

MEDICAID NUMBER

MEDICAID STATE

NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER

USMLE NUMBER (WITHOUT HYPHENS)

WORKERS COMPENSATION NUMBER

0 — — —

ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)

ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) (M M D D Y Y Y Y)

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 — Education and Training

Undergraduate School(s)

Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.

Professional School(s)

Provide the appropriate information for the school that issued your professional degree.

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway institution where you completed your training on Supplemental Page 20.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY | STATE | ZIP/POSTAL CODE

COUNTRY CODE | TELEPHONE | FAX

START DATE (M M Y Y Y Y) | END DATE (GRADUATION DATE) (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

GRADUATE TYPE*:

☐ U.S. OR CANADIAN GRADUATE ☐ NON-U.S./CANADIAN GRADUATE ☐ FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./ CANADIAN ONLY) | NAME OF U.S./ CANADIAN SCHOOL:

START DATE* (M M Y Y Y Y) | END DATE (GRADUATION DATE)* (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY | COUNTRY CODE | POSTAL CODE

START DATE* (M M Y Y Y Y) | END DATE (GRADUATION DATE)* (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

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Section 2 — Education and Training (Continued)

Training

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

COUNTRY CODE | TELEPHONE | FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? YES NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY | FELLOWSHIP | OTHER | START DATE (MMYYYY) | END DATE (MMYYYY)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY | FELLOWSHIP | OTHER | START DATE (MMYYYY) | END DATE (MMYYYY)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY | FELLOWSHIP | OTHER | START DATE (MMYYYY) | END DATE (MMYYYY)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

For 20201001 BOD Review Only

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 — Professional / Medical Specialty Information

Primary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Secondary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 Professional / Medical Specialty Information (Continued)

Certifications

Do you hold the following certifications? If yes, provide expiration dates.

			EXPIRATION DATE				EXPIRATION DATE
BASIC LIFE SUPPORT?*	YES	NO	M M D D Y Y Y Y	ADV LIFE SUPPORT IN OB?*	YES	NO	M M D D Y Y Y Y
CPR?*	YES	NO	M M D D Y Y Y Y	ADV TRAUMA LIFE SUPPORT?*	YES	NO	M M D D Y Y Y Y
ADV CARDIAC LIFE SPT?*	YES	NO	M M D D Y Y Y Y	PEDIATRIC ADVANCED LIFE SPT?*	YES	NO	M M D D Y Y Y Y
NEONATAL ADVANCED LIFE SPT?*	YES	NO	M M D D Y Y Y Y				

Practice Interests

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

Primary Credentialing Contact

CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE CREDENTIALING INFORMATION.

LAST NAME

FIRST NAME M.I.

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP CODE

TELEPHONE FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the e-mail address, if available.

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

IF NO, WHAT IS YOUR EXPECTED START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* ☐ YES ☐ NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

For 20201001 BOD Review Only

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* ☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION ☐

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

TELEPHONE* FAX

E-MAIL ADDRESS

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* ☐ YES ☐ NO IF YES ☐ ANSWERING SERVICE ☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE ☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* ☐ YES ☐ NO

ACCEPT ALL NEW PATIENTS?* ☐ YES ☐ NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* ☐ YES ☐ NO

ACCEPT NEW MEDICARE PATIENTS?* ☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* ☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?* ☐ YES ☐ NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS?* ☐ YES ☐ NO IF YES

GENDER LIMITATIONS ☐ MALE ONLY ☐ NONE ☐ FEMALE ONLY

AGE LIMITATIONS ☐☐ MINIMUM AGE ☐☐ MAXIMUM AGE

LIST OTHER LIMITATIONS

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Mid-Level Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* ☐ YES ☐ NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Languages

Code lists are found on pages 37. Enter the associated 3-digit code in the space provided.

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? YES NO	ALLERGY INJECTIONS? YES NO	ALLERGY SKIN TESTING? YES NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO
DRAWING BLOOD? YES NO	AGE APPROPRIATE IMMUNIZATIONS? YES NO	FLEXIBLE SIGMOIDOSCOPY? YES NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO
ASTHMA TREATMENT? YES NO	OSTEOPATHIC MANIPULATION? YES NO	IV HYDRATION/ TREATMENT? YES NO	CARDIAC STRESS TEST? YES NO
PULMONARY FUNCTION TESTING? YES NO	PHYSICAL THERAPY? YES NO	CARE OF MINOR LACERATIONS? YES NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Partners/ Associates

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | PROVIDER TYPE (CODE PG 36)

Section 5 — Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES?* YES NO

IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

For 20201001 BOD Review Only

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5 — Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (M M Y Y Y Y) | AFFILIATION END DATE (M M Y Y Y Y) | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (M M Y Y Y Y) | AFFILIATION END DATE (M M Y Y Y Y) | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

For 20201001 BOD Review Only

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 — Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT
IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION. ☐

SELF-INSURED?* ☐ YES ☐ NO

CARRIER OR SELF-INSURED NAME*

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (MM YYYY) | EFFECTIVE DATE* (MM YYYY) | EXPIRATION DATE (MM YYYY)

TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* ☐ YES ☐ NO

$ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional Insurance, use the Supplemental Insurance Form on page 31.

SELF-INSURED? ☐ YES ☐ NO

CARRIER OR SELF-INSURED NAME

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (MM YYYY) | EFFECTIVE DATE* (MM YYYY) | EXPIRATION DATE (MM YYYY)

TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? ☐ YES ☐ NO

$ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

For 20201001 BOD Review Only

Section 7 — Work History and References

Military Duty

Are you currently on active military duty or military reserve?* ☐ YES ☐ NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

If you have additional work history, use the Supplemental Work History Form on page 32.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 — Work History and References (Continued)

Work History

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity

If you have additional work history, use the Supplemental Work History Form on page 32.

TELEPHONE FAX

COUNTRY CODE START DATE (M M Y Y Y Y) END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP/POSTAL CODE

TELEPHONE FAX

COUNTRY CODE START DATE (M M Y Y Y Y) END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP/POSTAL CODE

TELEPHONE FAX

COUNTRY CODE START DATE (M M Y Y Y Y) END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

For 20201001 BOD Review Only

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 — Work History and References (Continued)

Gaps in Professional / Work History

If you have additional professional / work history gaps, use the Supplemental Professional Work History Gaps Form on page 33.

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALED.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 36-43. Enter the associated 3-digit code for provider type.

NOTE:

You are required to provide exactly 3 references. Your application will not be complete without this information.

Please check with credentialing entity for any special requirements.

Reference 1

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Reference 2

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Reference 3

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

For 20201001 BOD Review Only

Section 8 — Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

LICENSURE

1. ☐ YES ☐ NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
2. ☐ YES ☐ NO Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ YES ☐ NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
4. ☐ YES ☐ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
5. ☐ YES ☐ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ☐ YES ☐ NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
7. ☐ YES ☐ NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
8. ☐ YES ☐ NO Have any of your board certifications or eligibility ever been revoked?*
9. ☐ YES ☐ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. ☐ YES ☐ NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. ☐ YES ☐ NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

OTHER SANCTIONS OR INVESTIGATIONS

12. ☐ YES ☐ NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
13. ☐ YES ☐ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
14. ☐ YES ☐ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
15. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
16. ☐ YES ☐ NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ YES ☐ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
18. ☐ YES ☐ NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

For 2020 1001 BOD Review Only

Section 8 — Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. ☐ YES ☐ NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

20. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*

21. ☐ YES ☐ NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

22. ☐ YES ☐ NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

23. ☐ YES ☐ NO Are you currently engaged in the illegal use of drugs?*
("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. ☐ YES ☐ NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*

25. ☐ YES ☐ NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

26. ☐ YES ☐ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

For 20201001 BOD Review Only

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

For 2020 1001 BOD Preview Only

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

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Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 — Personal Information and Professional IDs

Professional IDs

Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

For 2201001 BOD Review Only

Other Relevant Education
Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 | **Education and Training**

Fifth Pathway Education

FIFTH PATHWAY GRADUATES ONLY

INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)

ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY)

Other Relevant Education

If you need to report additional Education, photocopy this page as needed and submit as instructed.

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

For 20201001 BOD Review Only

Other Training
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 — Education and Training

Training

List all postgraduate training programs you attended. Use one section per institution.

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

COUNTRY CODE | TELEPHONE | FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? YES NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

For 20201001 BOD Review Only

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Additional Specialty
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 — Professional / Medical Specialty Information

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Specialties, photocopy this page as needed and submit as instructed.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

For 20201001 BOD Review Only

Partners/Associates
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4
Partner/ Associates

Use this page to report additional partners/associates at the designated practice location.

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

Check "Covering Colleague?" if he/she provides coverage for you at THIS location.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional partners/associates, photocopy this page as needed and submit as instructed.

Practice Location Information

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # **PRIMARY PRACTICE** **PRACTICE NAME**

PRACTICE ADDRESS

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME / M.I.	PROVIDER TYPE (CODE PG 36)	

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME / M.I.	PROVIDER TYPE (CODE PG 36)	

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME / M.I.	PROVIDER TYPE (CODE PG 36)	

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME / M.I.	PROVIDER TYPE (CODE PG 36)	

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME / M.I.	PROVIDER TYPE (CODE PG 36)	

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME / M.I.	PROVIDER TYPE (CODE PG 36)	

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME / M.I.	PROVIDER TYPE (CODE PG 36)	

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME / M.I.	PROVIDER TYPE (CODE PG 36)	

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Covering Colleagues
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — **Practice Location Information**

Covering Colleagues

Include all colleagues providing regular coverage and his/her specialty, including if he/she is a partner in one or more of your practice locations.

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Covering Colleagues, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # ☐☐ ☐ **PRIMARY PRACTICE**

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME			SPECIALTY CODE
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)
LAST NAME			SPECIALTY CODE
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)
LAST NAME			SPECIALTY CODE
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)
LAST NAME			SPECIALTY CODE
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)
LAST NAME			SPECIALTY CODE
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)
LAST NAME			SPECIALTY CODE
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)
LAST NAME			SPECIALTY CODE
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)
LAST NAME			SPECIALTY CODE
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 1 of 5**

Additional Practice Location

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

LOCATION* #

CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO

IF NO, WHAT IS YOUR EXPECTED START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* YES NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* USE INDIVIDUAL TAX ID USE GROU TAX ID

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

For 20201001 BOD Review Only

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 2 of 5**

Add'l Practice Location (Cont.)

LOCATION* #

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

24/7 PHONE COVERAGE?* YES NO

IF YES ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO

ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO

ACCEPT NEW MEDICARE PATIENTS?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

ACCEPT NEW MEDICAID PATIENTS?* YES NO

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO

IF YES

GENDER LIMITATIONS: MALE ONLY NONE FEMALE ONLY

AGE LIMITATIONS: MINIMUM AGE MAXIMUM AGE

LIST OTHER LIMITATIONS

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 3 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* YES NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

Mid-Level Practitioners

PRACTITIONER LAST NAME
PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)
PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME
PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)
PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME
PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)
PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME
PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)
PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME
PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)
PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 4 of 5**

Additional Practice Location (Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? YES NO	ALLERGY INJECTIONS? YES NO	ALLERGY SKIN TESTING? YES NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO
DRAWING BLOOD? YES NO	AGE APPROPRIATE IMMUNIZATIONS? YES NO	FLEXIBLE SIGMOIDOSCOPY? YES NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO
ASTHMA TREATMENT? YES NO	OSTEOPATHIC MANIPULATION? YES NO	IV HYDRATION/ TREATMENT? YES NO	CARDIAC STRESS TEST? YES NO
PULMONARY FUNCTION TESTING? YES NO	PHYSICAL THERAPY? YES NO	CARE OF MINOR LACERATIONS? YES NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

For 20201001 BOD Review Only

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 5 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

LOCATION* #

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

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Hospital Privileges (Current)
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5 | **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (MMYYYY) | AFFILIATION END DATE (MMYYYY) | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

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THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

Professional Liability Insurance Carrier
Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 | **Professional Liability Insurance Carrier**

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

CARRIER OR SELF-INSURED NAME | SELF-INSURED? YES NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

CARRIER OR SELF-INSURED NAME | SELF-INSURED? YES NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

For 20201001 BOD Review Only

Work History
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 | **Work History**

Work History

Use this form to continue listing work history.

If you need additional space for Work History, photocopy this page as needed and submit as instructed.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (MMYYYY)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (MMYYYY)

REASON FOR DEPARTURE (IF APPLICABLE)

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Professional Training / Work History Gaps
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 | **Professional Training / Work History Gaps**

Professional Training / Work History Gaps

Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three month in duration or of a shorter duration if required by the organization for which you are being credentialed.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

For 20201001 BOD Review Only

Disclosure Questions
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 | **Disclosure Questions**

Disclosure Questions

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the question number in the first column, then your explanation in the second column.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

For 20201001 BOD Review Only

Malpractice Claims Explanation
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 | **Malpractice Claims Explanation**

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

DATE OF OCCURRENCE* M M D D Y Y Y Y

DATE CLAIM WAS FILED* M M D D Y Y Y Y

STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN)

☐ OPEN ☐ CLOSED

IF SETTLED, ENTER DATE CLAIM WAS SETTLED M M D D Y Y Y Y

PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE POLICY NUMBER

$, , AMOUNT OF AWARD OR SETTLEMENT*

METHOD OF RESOLUTION?* ☐ DISMISSED ☐ SETTLED ☐ MEDIATION ☐ ARBITRATION ☐ JUDGMENT FOR DEFENDANT(S) ☐ JUDGMENT FOR PLAINTIFF(S)

DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY)

WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?* ☐ PRIMARY DEFENDANT ☐ CO-DEFENDANT

NUMBER OF OTHER CO-DEFENDANTS (IF ANY)

YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY)

DID THE ALLEGED INJURY RESULT IN DEATH? ☐ YES ☐ NO

TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?* ☐ YES ☐ NO

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Code Lists

Provider Type Codes

001 Medical Doctor (MD)
002 Doctor of Dental Surgery (DDS)
003 Doctor of Dental Medicine (DMD)
004 Doctor of Podiatric Medicine (DPM)
005 Doctor of Chiropractic (DC)
007 Osteopathic Doctor (DO)

020 Acupuncturist
021 Alcohol/Drug Counselor
022 Audiologist
023 Biofeedback Technician
024 Certified Registered Nurse Anesthetist
025 Christian Science Practitioner
026 Clinical Nurse Specialist
027 Clinical Psychologist
028 Clinical Social Worker
029 Dietician
030 Licensed Practical Nurse
031 Marriage/Family Therapist
032 Massage Therapist
033 Naturopath
034 Neuropsychologist
035 Midwife
036 Nurse Midwife
037 Nurse Practitioner
038 Nutritionist
039 Occupational Therapist
040 Optician
041 Optometrist
042 Pharmacist
043 Physical Therapist
044 Physician Assistant
045 Professional Counselor
046 Registered Nurse
047 Registered Nurse First Assistant
048 Respiratory Therapist
049 Speech Pathologist

License Status Codes

001 Active
002 Canceled
003 Denied
004 Expired
005 Inactive
006 Lapsed
007 Limited
008 Pending
009 Probation
010 Provisional
011 Restricted
012 Revoked
013 Suspended
014 Surrendered
015 Temporary
016 Terminated
017 Time Limited
018 Unrestricted
019 Other

Country Codes

004 Afghanistan
008 Albania
012 Algeria
016 American Samoa
020 Andorra
024 Angola
660 Anguilla
010 Antarctica
028 Antigua and Barbuda
032 Argentina
051 Armenia
533 Aruba
036 Australia
040 Austria
031 Azerbaijan
044 Bahamas
048 Bahrain
050 Bangladesh
052 Barbados
112 Belarus
056 Belgium
084 Belize
204 Benin
060 Bermuda
064 Bhutan
068 Bolivia
070 Bosnia and Herzegovina
072 Botswana
074 Bouvet Island
076 Brazil
086 British Indian Ocean Territory
096 Brunei Darussalam
100 Bulgaria
854 Burkina Faso
108 Burundi
116 Cambodia
120 Cameroon
124 Canada
132 Cape Verde
136 Cayman Islands
140 Central African Republic
148 Chad
152 Chile
156 China
162 Christmas Island
166 Cocos (Keeling) Islands
170 Colombia
174 Comoros
178 Congo
180 Congo, Democratic Republic of the
184 Cook Islands
188 Costa Rica
384 Cote d'Ivoire
191 Croatia
192 Cuba
196 Cyprus
203 Czech Republic
208 Denmark
262 Djibouti
212 Dominica
214 Dominican Republic
626 East Timor (provisional)
218 Ecuador
818 Egypt
222 El Salvador
226 Equatorial Guinea
232 Eritrea
233 Estonia
231 Ethiopia
238 Falkland Islands (Malvinas)
234 Faroe Islands
242 Fiji
246 Finland
250 France
249 France, Metropolitan
254 French Guiana
258 French Polynesia
260 French Southern Territories
266 Gabon
270 Gambia
268 Georgia
276 Germany
288 Ghana
292 Gibraltar
300 Greece
304 Greenland
308 Grenada
312 Guadaloupe
316 Guam
320 Guatemala
324 Guinea
624 Guinea-Bissau
328 Guyana
332 Haiti
334 Heard Island and McDonald Islands
340 Honduras
344 Hong Kong
348 Hungary
352 Iceland
356 India
360 Indonesia
364 Iran
368 Iraq
372 Ireland
376 Israel
380 Italy
388 Jamaica
392 Japan
400 Jordan
398 Kazakhstan
404 Kenya
296 Kiribati
408 Korea, North
410 Korea, South
414 Kuwait
417 Kyrgyzstan
418 Laos
428 Latvia
422 Lebanon
426 Lesotho
430 Liberia
434 Libya
438 Liechtenstein
440 Lithuania
442 Luxembourg
446 Macau
807 Macedonia
450 Madagascar
454 Malawi
458 Malaysia
462 Maldives
466 Mali
470 Malta
584 Marshall Islands
474 Martinique
478 Mauritania
480 Mauritius
175 Mayotte
484 Mexico
583 Micronesia
498 Moldova
492 Monaco
496 Mongolia
500 Montserrat
504 Morocco
508 Mozambique
104 Myanmar
516 Namibia
520 Nauru
524 Nepal
528 Netherlands
530 Netherlands Antilles
540 New Caledonia
554 New Zealand
558 Nicaragua
562 Niger
566 Nigeria
570 Niue
574 Norfolk Island
580 Northern Mariana Islands
578 Norway
512 Oman
586 Pakistan
585 Palau
591 Panama
598 Papua New Guinea
600 Paraguay
604 Peru
608 Philippines
612 Pitcairn
616 Poland
620 Portugal
630 Puerto Rico
634 Qatar
638 Réunion
642 Romania
643 Russian Federation
646 Rwanda
654 Saint Helena
659 Saint Kitts and Nevis
662 Saint Lucia
666 Saint Pierre and Miquelon
670 Saint Vincent and the Grenadines

For 20201001 BOD Review Only

Code Lists

Country Codes (continued)

882	Samoa
674	San Marino
678	São Tomé and Príncipe
682	Saudi Arabia
683	Scotland
686	Senegal
690	Seychelles
694	Sierra Leone
702	Singapore
703	Slovakia
705	Slovenia
090	Solomon Islands
706	Somalia
710	South Africa
239	South Georgia and the South Sandwich Islands
724	Spain
144	Sri Lanka
736	Sudan
740	Suriname
744	Svalbard and Jan Mayen
748	Swaziland
752	Sweden
756	Switzerland
760	Syria
158	Taiwan
762	Tajikistan
834	Tanzania
764	Thailand
768	Togo
772	Tokelau
776	Tonga
780	Trinidad and Tobago
788	Tunisia
792	Turkey795 Turkmenistan
796	Turks and Caicos Islands
798	Tuvalu
800	Uganda
804	Ukraine
784	United Arab Emirates
826	United Kingdom
840	United States
581	U.S. Minor Outlying Islands
858	Uruguay
860	Uzbekistan
548	Vanuatu
336	Vatican City State (Holy See)
862	Venezuela
704	Viet Nam
092	Virgin Islands, British
850	Virgin Islands, U.S.
876	Wallis and Fortuna Islands
732	Western Sahara (provisional)
887	Yemen
891	Yugoslavia
894	Zambia
716	Zimbabwe

Language Codes

001	Abkhazian
002	Afan (Oromo)
003	Afar
004	Afrikaans
005	Albanian
006	Amharic
007	Arabic
008	Armenian
009	Assamese
010	Zerbaijani
011	Bashkir
012	Basque
013	Bengali;Bangla
014	Bhutani
015	Bihari
016	Bislama
017	Breton
018	Bulgarian
019	Burmese
020	Byelorussian
021	Cambodian
022	Catalan
023	Chinese
024	Corsican
025	Croatian
026	Czech
027	Danish
028	Dutch
140	English
030	Esperonto
031	Estonian
032	Faroese
033	Fiji
034	Finnish
035	French
036	Frisian
037	Galican
038	Georgian
039	German
040	Greek
041	Greenlandic
042	Guarani
043	Gujarati
044	Hausa
045	Hebrew
046	Hindi
047	Hungarian
048	Icelandic
049	Indonesian
050	Interlingua
051	Interlingue
052	Inuktitut
053	Inupiak
054	Irish
055	Italian
056	Japanese
057	Javanese
058	Kannada
059	Kashmiri
060	Kazakh
061	Kinyarwanda
062	Kirghiz
063	Kurundi
064	Korean
065	Kurdish
066	Laothian
067	Latin
068	Latvian;Lettish
069	Lingala
070	Lithuanian
071	Macedonian
072	Malagasy
073	Malay
074	Malayalam
075	Maltese
076	Maori
077	Marathi
078	Moldavian
079	Mongolian
080	Nauru
081	Nepali
082	Norwegian
083	Occitan
084	Oriya
085	Pashto;Pushto
086	Persian (Farsi)
087	Polish
088	Portuguese
089	Punjabi
090	Quechua
091	Rhaeto-Romance
092	Romanian
093	Russian
094	Samoan
095	Sangho
096	Sanskrit
097	Scot Gaelic
098	Serbian
099	Serbo-Croatian
100	Sesotho
101	Setswana
102	Shona
103	Sindhi
104	Singhalese
105	Siswati
106	Slovak
107	Slovenian
108	Somali
109	Spanish
110	Sundanese
111	Swahili
112	Swedish
113	Tagalog
114	Tajik
115	Tamil
116	Tatar
117	Telugu
118	Thai
119	Tibetan
120	Tigrinya
121	Tonga
122	Tsonga
123	Turkish
124	Turkmen
125	Twi
126	Uigur
127	Ukrainian
128	Urdu
129	Uzbek
130	Vietnamese
131	Volapuk
132	Welsh
133	Wolof
134	Xhosa
135	Yiddish
136	Yoruba
10	Zerbaijani
137	Zhuang
138	Zulu

For 20201001 BOD Review Only

Code Lists

U.S. / Canadian Professional School Codes

Alabama
300 University of Alabama School of Dentistry
001 University of Alabama School of Medicine
002 University of South Alabama College of Medicine

Arkansas
003 University of Arkansas College of Medicine

Arizona
500 Arizona College of Osteopathic Medicine
004 University of Arizona College of Medicine

California
801 California College of Podiatric Medicine
400 Cleveland Chiropractic College of Los Angele
005 Keck School of Medicine
401 Life Chiropractic College West
301 Loma Linda University School of Dentistry
006 Loma Linda University School of Medicine
402 Los Angeles College of Chiropractic
403 Palmer College of Chiropractic West
404 Quantum University/SCCC
007 Stanford University School of Medicine
501 Touro University College of Osteopathic Medicine
008 UCLA School of Medicine
009 University of California
010 University of California, Irvine, College of Medicine
302 University of California, Los Angeles School of Dentistry
011 University of California, San Diego, School of Medicine
303 University of California, San Francisco, School of Dentistry
012 University of California, San Francisco, School of Medicine
304 University of Southern California School of Dentistry
305 University of the Pacific School of Dentistry
502 Western University of Health Sciences, College of Osteopathic Medicine of the Pacific

Colorado
306 University of Colorado School of Dentistry
013 University of Colorado School of Medicine

Connecticut
405 University of Bridgeport College of Chiropractic
307 University of Connecticut School of Dental Medicine
014 University of Connecticut School of Medicine
015 Yale University School of Medicine

District of Columbia
016 George Washington University
017 Georgetown University School of Medicine
308 Howard University College of Dentistry
018 Howard University College of Medicine

Florida
800 Barry University School of Graduate Medical Sciences
309 Nova Southeastern University College of Dentistry
503 Nova Southeastern University College of Osteopathic Medicine
310 University of Florida College of Dentistry
019 University of Florida College of Medicine
020 University of Miami School of Medicine
021 University of South Florida College of Medicine

Georgia
022 Emory University School of Medicine
406 Life Chiropractic College
311 Medical College of Georgia School of Dentistry
023 Medical College of Georgia School of Medicine
024 Mercer University School of Medicine
025 Morehouse School of Medicine

Hawaii
026 John A. Burns School of Medicine

Iowa
802 College of Podiatric Medicine and Surgery Des Moines University
504 Des Moines University, Osteopathic Medical Center, College of Osteopathic Medicine and Surgery
407 Palmer College of Chiropractic
312 University of Iowa College of Dentistry
027 University of Iowa College of Medicine

Illinois
028 Chicago Medical School, Finch University of Health Sciences
029 Loyola University Chicago, Stritch School of Medicine
505 Midwestern University, Chicago College of Osteopathic Medicine
408 National College of Chiropractic
313 Northwestern University Dental School
030 Northwestern University Medical School
031 Rush Medical College of Rush University
804 Scholl College of Podiatric Medicine at Finch University
314 Southern Illinois University School of Dental Medicine
032 Southern Illinois University School of Medicine
033 University of Chicago, The Pritzker School of Medicine
315 University of Illinois at Chicago College of Dentistry
034 University of Illinois College of Medicine

Indiana
316 Indiana University School of Dentistry
035 Indiana University School of Medicine

Kansas
036 University of Kansas School of Medicine

Kentucky
506 Pikeville College, School of Osteopathic Medicine
317 University of Kentucky College of Dentistry
037 University of Kentucky College of Medicine
318 University of Louisville School of Dentistry
038 University of Louisville School of Medicine

Louisiana
319 Louisiana State University School of Dentistry
039 Louisiana State University School of Medicine in New Orleans
040 Louisiana State University School of Medicine in Shreveport
041 Tulane University School of Medicine

Massachusetts
042 Boston University School of Medicine
320 Boston University, Goldman School of Dental Medicine
043 Harvard Medical School
321 Harvard School of Dental Medicine
322 Tufts University School of Dental Medicine
044 Tufts University School of Medicine
045 University of Massachusetts Medical School

Maryland
046 Johns Hopkins University School of Medicine
047 Uniformed Services University of the Health Sciences
048 University of Maryland School of Medicine
323 University of Maryland, Baltimore, College of Dental Surgery

Maine
507 University of New England, College of Osteopathic Medicine

Michigan
049 Michigan State University College of Human Medicine
508 Michigan State University, College of Osteopathic Medicine
324 University of Detroit Mercy School of Dentistry
050 University of Michigan Medical School
325 University of Michigan School of Dentistry
051 Wayne State University School of Medicine

Minnesota
052 Mayo Medical School
409 Northwestern College of Chiropractic
053 University of Minnesota, Duluth School of Medicine
054 University of Minnesota Medical School, Twin Cities
326 University of Minnesota School of Dentistry

Missouri
410 Cleveland Chiropractic College of Kansas City
509 Kirksville College of Osteopathic Medicine
411 Logan Chiropractic College
055 Saint Louis University School of Medicine
510 University of Health Sciences, College of Osteopathic Medicine

056 University of Missouri, Columbia School of Medicine
327 University of Missouri Kansas City School of Dentistry
057 University of Missouri Kansas City School of Medicine
058 Washington University in St. Louis School of Medicine

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Code Lists

U.S. / Canadian Professional School Codes (continued)

Mississippi
328 University of Mississippi School of Dentistry
059 University of Mississippi School of Medicine

North Carolina
060 Duke University School of Medicine
061 The Brody School of Medicine at East Carolina University
329 University of North Carolina at Chapel Hill School of Dentistry
062 University of North Carolina at Chapel Hill School of Medicine
063 Wake Forest University School of Medicine

North Dakota
064 University of North Dakota School of Medicine and Health Sciences

Nebraska
330 Creighton University School of Dentistry
065 Creighton University School of Medicine
066 University of Nebraska College of Medicine
331 University of Nebraska Medical Center, College of Dentistry

New Hampshire
067 Dartmouth Medical School

New Jersey
068 Robert Wood Johnson Medical School
069 University of Medicine and Dentistry of New Jersey (UMDNJ)
332 UMDNJ, New Jersey Dental School
511 UMDNJ, School of Osteopathic Medicine

New Mexico
070 University of New Mexico School of Medicine

Nevada
071 University of Nevada School of Medicine

New York
072 Albany Medical College
073 Albert Einstein College of Medicine
074 Columbia University College of Physicians and Surgeons
333 Columbia University School of Dental and Oral Surgery
075 Joan & Sanford I. Weill Medical College of Cornell University
076 Mount Sinai School of Medicine of New York University
412 New York Chiropractic College
512 NY College of Osteopathic Medicine of the NY Institute of Technology
077 New York Medical College
334 New York University Kriser Dental Center
078 New York University School of Medicine
335 State University of New York at Buffalo School of Dental Medicine
082 State University of New York at Buffalo School of Medicine
336 State University of New York at Stony Brook School of Dental Medicine
081 State University of New York at Stony Brook School of Medicine
079 State University of New York College of Medicine
080 State University of New York Upstate Medical University
083 University of Rochester School of Medicine and Dentistry

Ohio
337 Case Western Reserve University School of Dentistry
084 Case Western Reserve University School of Medicine
085 Medical College of Ohio
086 Northeastern Ohio Universities College of Medicine
803 Ohio College of Podiatric Medicine
338 Ohio State University College of Dentistry
087 Ohio State University College of Medicine and Public Health
513 Ohio University College of Osteopathic Medicine
088 University of Cincinnati College of Medicine
089 Wright State University School of Medicine

Oklahoma
514 Oklahoma State University, College of Osteopathic Medicine
339 University of Oklahoma College of Dentistry
090 University of Oklahoma College of Medicine

Oregon
091 Oregon Health & Science University School of Medicine
340 Oregon Health Sciences University School of Dentistry
413 Western States Chiropractic College

Pennsylvania
092 Jefferson Medical College of Thomas Jefferson University
515 Lake Erie College of Osteopathic Medicine
093 MCP Hahnemann University School of Medicine
094 Pennsylvania State University College of Medicine
516 Philadelphia College of Osteopathic Medicine
341 Temple University School of Dentistry
095 Temple University School of Medicine
805 Temple University School of Podiatric Medicine
342 University of Pennsylvania School of Dental Medicine
096 University of Pennsylvania School of Medicine
343 University of Pittsburgh School of Dental Medicine
097 University of Pittsburgh School of Medicine

Puerto Rico
098 Ponce School of Medicine
099 Universidad Central del Caribe School of Medicine
100 University of Puerto Rico School of Medicine
344 University of Puerto Rico School of Dentistry

Rhode Island
101 Brown Medical School

South Carolina
345 Medical University of South Carolina College of Dental Medicine
102 Medical University of South Carolina College of Medicine
414 Sherman College of Chiropractic
103 University of South Carolina School of Medicine

South Dakota
104 University of South Dakota School of Medicine

Tennessee
105 East Tennessee State University
346 Meharry Medical College School of Dentistry
106 Meharry Medical College School of Medicine
347 University of Tennessee College of Dentistry
107 University of Tennessee College of Medicine
108 Vanderbilt University School of Medicine

Texas
348 Baylor College of Dentistry
109 Baylor College of Medicine
415 Parker College of Chiropractic
416 Texas Chiropractic College
110 Texas Tech University Health Sciences Center School of Medicine
111 The Texas A & M University System College of Medicine
517 UNT Health Sciences Center, Texas College of Osteopathic Medicine
349 University of Texas Health Science Center at Houston Dental School
350 University of Texas Health Science Center at San Antonio Dental School
112 University of Texas Medical Branch at Galveston
113 University of Texas Medical School at Houston
114 University of Texas Medical School at San Antonio
115 UT Southwestern Medical Center at Dallas Southwestern Medical School

Utah
116 University of Utah School of Medicine

Virginia
117 Eastern VA Medical School of the Medical College of Hampton Roads
118 University of Virginia School of Medicine Health System
351 Virginia Commonwealth University School of Dentistry
119 Virginia Commonwealth University School of Medicine

Vermont
120 University of Vermont College of Medicine

Washington
352 University of Washington School of Dentistry
121 University of Washington School of Medicine

Wisconsin
353 Marquette University School of Dentistry
122 Medical College of Wisconsin
123 University of Wisconsin Medical School

West Virginia
124 Joan C. Edwards School of Medicine at Marshall University
518 West Virginia School of Osteopathic Medicine
354 West Virginia University School of Dentistry
125 West Virginia University School of Medicine

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Code Lists

U.S. / Canadian Professional School Codes (continued)

Canada

355 Dalhousie University Faculty of Dentistry
126 Dalhousie University Faculty of Medicine
357 Laval University Faculty of Dentistry
127 Laval University Faculty of Medicine
356 McGill University Faculty of Dentistry
128 McGill University Faculty of Medicine
129 McMaster University School of Medicine
130 Memorial University of Newfoundland Faculty of Medicine
131 Queen's University Faculty of Health Sciences
132 The University of Western Ontario Faculty of Medicine & Dentistry
133 Universite de Montreal Faculty of Medicine
134 Universite de Sherbrooke Faculty of Medicine
358 University of Alberta Faculty of Dentistry
135 University of Alberta Faculty of Medicine
359 University of British Columbia Faculty of Dentistry
136 University of British Columbia Faculty of Medicine
137 University of Calgary Faculty of Medicine
360 University of Manitoba Faculty of Dentistry
138 University of Manitoba Faculty of Medicine
361 University of Montreal Faculty of Dentistry
139 University of Ottawa Faculty of Medicine
362 University of Saskatchewan College of Dentistry
140 University of Saskatchewan College of Medicine
363 University of Toronto Faculty of Dentistry
141 University of Toronto Faculty of Medicine
364 University of Western Ontario Faculty of Dentistry

Specialty Codes - MD / DO Only

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

247 Allergy & Immunology
246 Allergy & Immunology, Allergy
291 Allergy & Immunology, Clinical & Laboratory Immunology
249 Anesthesiology
235 Anesthesiology, Addiction Medicine
258 Anesthesiology, Critical Care Medicine
126 Anesthesiology, Pain Medicine
363 Clinical Pharmacology
367 Colon & Rectal Surgery
263 Dermatology
292 Dermatology, Clinical & Laboratory Dermatological Immunology
444 Dermatology, Dermatological Surgery
266 Dermatology, Dermatopathology
264 Dermatology, MOHS-Micrographic Surgery
443 Dermatology, Pediatric Dermatology
268 Emergency Medicine
445 Emergency Medicine, Emergency Medical Services
427 Emergency Medicine, Medical Toxicology
348 Emergency Medicine, Pediatric Emergency Medicine
395 Emergency Medicine, Sports Medicine
446 Emergency Medicine, Undersea and Hyperbaric Medicine
391 Facial Plastic Surgery
272 Family Practice
447 Family Practice, Addiction Medicine
237 Family Practice, Adolescent Medicine
448 Family Practice, Adult Medicine
282 Family Practice, Geriatric Medicine
396 Family Practice, Sports Medicine
225 General Practice
479 Hospitalist
301 Internal Medicine
449 Internal Medicine, Addiction Medicine
236 Internal Medicine, Adolescent Medicine
248 Internal Medicine, Allergy & Immunology
255 Internal Medicine, Cardiovascular Disease
294 Internal Medicine, Clinical & Laboratory Immunology
253 Internal Medicine, Clinical Cardiac Electrophysiology
257 Internal Medicine, Critical Care Medicine
267 Internal Medicine, Endocrinology, Diabetes & Metabolism
275 Internal Medicine, Gastroenterology
285 Internal Medicine, Geriatric Medicine
287 Internal Medicine, Hematology
288 Internal Medicine, Hematology & Oncology
450 Internal Medicine, Hepatology
299 Internal Medicine, Infectious Disease
451 Internal Medicine, Interventional Cardiology
453 Internal Medicine, Magnetic Resonance Imaging (MRI)
325 Internal Medicine, Medical Oncology
309 Internal Medicine, Nephrology
378 Internal Medicine, Pulmonary Disease
390 Internal Medicine, Rheumatology
397 Internal Medicine, Sports Medicine
433 Laboratories, Clinical Medical Laboratory
481 Legal Medicine
278 Medical Genetics, Clinical Biochemical Genetics
261 Medical Genetics, Clinical Cytogenetic
277 Medical Genetics, Clinical Genetics (M.D.)
280 Medical Genetics, Clinical Molecular Genetics
455 Medical Genetics, Molecular Genetic Pathology
454 Medical Genetics, Ph.D. Medical Genetics
306 Neonatal-Perinatal Medicine
308 Neopathology
409 Neurological Surgery
330 Neuromusculoskeletal Medicine & OMM
440 Neuromusculoskeletal Medicine, Sports Medicine
317 Nuclear Medicine
318 Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine
315 Nuclear Medicine, Nuclear Cardiology
316 Nuclear Medicine, Nuclear Imaging & Therapy
321 Obstetrics & Gynecology
260 Obstetrics & Gynecology, Critical Care Medicine
326 Obstetrics & Gynecology, Gynecologic Oncology
286 Obstetrics & Gynecology, Gynecology
303 Obstetrics & Gynecology, Maternal & Fetal Medicine
320 Obstetrics & Gynecology, Obstetrics
271 Obstetrics & Gynecology, Reproductive Endocrinology
328 Ophthalmology
441 Oral & Maxillofacial Surgery
411 Orthopaedic Surgery
412 Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery
456 Orthopaedic Surgery, Foot and Ankle Orthopaedics
406 Orthopaedic Surgery, Hand Surgery
415 Orthopaedic Surgery, Orthopaedic Surgery of the Spine
416 Orthopaedic Surgery, Orthopaedic Trauma
457 Orthopaedic Surgery, Sports Medicine
119 Orthopedic
331 Otolaryngology
458 Otolaryngology, Otolaryngic Allergy
459 Otolaryngology, Otolaryngology/ Facial Plastic Surgery
332 Otolaryngology, Otology & Neurotology
357 Otolaryngology, Pediatric Otolaryngology
417 Otolaryngology, Plastic Surgery within the Head & Neck
480 Pain Medicine, Interventional Pain Medicine
337 Pain Medicine
338 Pathology, Anatomic Pathology
340 Pathology, Anatomic Pathology & Clinical Pathology
250 Pathology, Blood Banking & Transfusion Medicine
344 Pathology, Chemical Pathology
302 Pathology, Clinical Pathology/Laboratory Medicine
262 Pathology, Cytopathology
265 Pathology, Dermatopathology
273 Pathology, Forensic Pathology
290 Pathology, Hematology
298 Pathology, Immunopathology
305 Pathology, Medical Microbiology
461 Pathology, Molecular Genetic Pathology
312 Pathology, Neuropathology
358 Pathology, Pediatric Pathology
244 Pediatrics
239 Pediatrics, Adolescent Medicine
295 Pediatrics, Clinical & Laboratory Immunology
462 Pediatrics, Developmental – Behavioral Pediatrics
354 Pediatrics, Medical Toxicology
356 Pediatrics, Neurodevelopmental Disabilities
345 Pediatrics, Pediatric Allergy & Immunology
346 Pediatrics, Pediatric Cardiology
347 Pediatrics, Pediatric Critical Care Medicine
463 Pediatrics, Pediatric Emergency Medicine
349 Pediatrics, Pediatric Endocrinology

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Code Lists

Specialty Codes - MD/DO Only

350	Pediatrics, Pediatric Gastroenterology
351	Pediatrics, Pediatric Hematology-Oncology
352	Pediatrics, Pediatric Infectious Diseases
355	Pediatrics, Pediatric Nephrology
359	Pediatrics, Pediatric Pulmonology
361	Pediatrics, Pediatric Rheumatology
398	Pediatrics, Sports Medicine
365	Physical Medicine & Rehabilitation
468	Physical Medicine & Rehabilitation, Pain Medicine
389	Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine
466	Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine
469	Physical Medicine & Rehabilitation, Sports Medicine
419	Plastic Surgery
470	Plastic Surgery, Plastic Surgery Within the Head and Neck
407	Plastic Surgery, Surgery of the Hand
242	Preventive Medicine, Aerospace Medicine
429	Preventive Medicine, Medical Toxicology
112	Preventive Medicine, Occupational Medicine
471	Preventive Medicine, Sports Medicine
431	Preventive Medicine, Undersea and Hyperbaric Medicine
114	Preventive Medicine/Occupational Environmental Medicine
370	Psychiatry & Neurology, Addiction Medicine
473	Psychiatry & Neurology, Addiction Psychiatry
371	Psychiatry & Neurology, Child & Adolescent Psychiatry
313	Psychiatry & Neurology, Clinical Neurophysiology
274	Psychiatry & Neurology, Forensic Psychiatry
373	Psychiatry & Neurology, Geriatric Psychiatry
472	Psychiatry & Neurology, Neurodevelopmental Disabilities
100	Psychiatry & Neurology, Neurology
311	Psychiatry & Neurology, Neurology with Special Qualifications in Child Neurology
474	Psychiatry & Neurology, Pain Medicine
368	Psychiatry & Neurology, Psychiatry
475	Psychiatry & Neurology, Sports Medicine
476	Psychiatry & Neurology, Vascular Neurology
366	Public Health & General Preventive Medicine
252	Radiology, Body Imaging
173	Radiology, Diagnostic Radiology
430	Radiology, Diagnostic Ultrasound
314	Radiology, Neuroradiology
319	Radiology, Nuclear Radiology
360	Radiology, Pediatric Radiology
380	Radiology, Radiation Oncology
477	Radiology, Radiological Physics
381	Radiology, Therapeutic Radiology
384	Radiology, Vascular & Interventional Radiology
434	Supplier
399	Surgery
418	Surgery, Pediatric Surgery
420	Surgery, Plastic and Reconstructive Surgery
405	Surgery, Surgery of the Hand
425	Surgery, Surgical Critical Care
413	Surgery, Surgical Oncology
423	Surgery, Trauma Surgery
400	Surgery, Vascular Surgery
421	Thoracic Surgery (Cardiothoracic Vascular Surgery)
442	Transplant Surgery
424	Urology

Specialty Codes - DDS / DMD / DPM / DC

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD

2	Dentist
13	Dentist, Dental Public Health
14	Dentist, Endodontics
438	Dentist, General Practice
16	Dentist, Oral and Maxillofacial Pathology
439	Dentist, Oral and Maxillofacial Radiology
20	Dentist, Oral and Maxillofacial Surgery
15	Dentist, Orthodontics and Dentofacial Orthopedics
17	Dentist, Pediatric Dentistry
18	Dentist, Periodontics
19	Dentist, Prosthodontics

DPM

3	Podiatrist
231	Podiatrist, Foot & Ankle Surgery
230	Podiatrist, Foot Surgery
225	Podiatrist, General Practice
227	Podiatrist, Primary Podiatric Medicine
226	Podiatrist, Public Medicine
228	Podiatrist, Radiology
229	Podiatrist, Sports Medicine

DC

1	Chiropractor
5	Chiropractor, Internist
6	Chiropractor, Neurology
7	Chiropractor, Nutrition
8	Chiropractor, Occupational Medicine
9	Chiropractor, Orthopedic
10	Chiropractor, Radiology
11	Chiropractor, Sports Physician
12	Chiropractor, Thermography

Specialty Codes - Allied Providers

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

501	Acupuncturist
503	Audiologist
504	Audiologist, Assistive Technology Practitioner
505	Audiologist, Assistive Technology Supplier
531	Christian Science Practitioner
727	Clinical Nurse Specialist
728	Clinical Nurse Specialist, Acute Care
729	Clinical Nurse Specialist, Adult Health
730	Clinical Nurse Specialist, Chronic Care
731	Clinical Nurse Specialist, Community Health/Public Health
732	Clinical Nurse Specialist, Critical Care Medicine
733	Clinical Nurse Specialist, Emergency
734	Clinical Nurse Specialist, Ethics
735	Clinical Nurse Specialist, Family Health
736	Clinical Nurse Specialist, Gerontology
737	Clinical Nurse Specialist, Holistic
738	Clinical Nurse Specialist, Home Health
739	Clinical Nurse Specialist, Informatics
740	Clinical Nurse Specialist, Long-Term Care
741	Clinical Nurse Specialist, Medical-Surgical
742	Clinical Nurse Specialist, Neonatal
743	Clinical Nurse Specialist, Neuroscience
744	Clinical Nurse Specialist, Occupational Health
745	Clinical Nurse Specialist, Oncology
746	Clinical Nurse Specialist, Oncology, Pediatrics
747	Clinical Nurse Specialist, Pediatrics
748	Clinical Nurse Specialist, Perinatal
749	Clinical Nurse Specialist, Perioperative
750	Clinical Nurse Specialist, Psychiatric/Mental Health
751	Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
752	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
753	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
754	Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
755	Clinical Nurse Specialist, Psychiatric/Mental Health, Community
756	Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
757	Clinical Nurse Specialist, Rehabilitation
759	Clinical Nurse Specialist, School
758	Clinical Nurse Specialist, Transplantation
760	Clinical Nurse Specialist, Women's Health
513	Counselor
514	Counselor, Addiction (Substance Use Disorder)
515	Counselor, Mental Health
516	Counselor, Professional
533	Dietitian, Registered
536	Dietitian, Registered, Nutrition, Metabolic
534	Dietitian, Registered, Nutrition, Pediatric
535	Dietitian, Registered, Nutrition, Renal
651	Licensed Practical Nurse
517	Marriage & Family Therapist
547	Massage Therapist
549	Midwife, Certified
652	Midwife, Certified Nurse
551	Naturopath
553	Neuropsychologist
653	Nurse Anesthetist, Certified Registered
654	Nurse Practitioner
655	Nurse Practitioner, Acute Care
656	Nurse Practitioner, Adult Health
658	Nurse Practitioner, Community Health
657	Nurse Practitioner, Critical Care Medicine
659	Nurse Practitioner, Family

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Code Lists

Specialty Codes - Allied Providers (continued)

660 Nurse Practitioner, Gerontology
661 Nurse Practitioner, Neonatal
662 Nurse Practitioner, Neonatal, Critical Care
670 Nurse Practitioner, Obstetrics & Gynecology
671 Nurse Practitioner, Occupational Health
663 Nurse Practitioner, Pediatrics
664 Nurse Practitioner, Pediatrics, Critical Care
666 Nurse Practitioner, Perinatal
667 Nurse Practitioner, Primary Care
665 Nurse Practitioner, Psych/Mental Health
668 Nurse Practitioner, School
669 Nurse Practitioner, Women's Health
537 Nutritionist
538 Nutritionist, Nutrition, Education
555 Occupational Therapist
556 Occupational Therapist, Ergonomics
557 Occupational Therapist, Hand
558 Occupational Therapist, Human Factors
559 Occupational Therapist, Neurorehabilitation
560 Occupational Therapist, Pediatrics
561 Occupational Therapist, Rehabilitation, Driver
563 Optician
565 Optometrist
566 Optometrist, Corneal and Contact Management
567 Optometrist, Low Vision Rehabilitation
571 Optometrist, Occupational Vision
568 Optometrist, Pediatrics
569 Optometrist, Sports Vision
570 Optometrist, Vision Therapy
573 Pharmacist
574 Pharmacist, General Practice
575 Pharmacist, Nuclear Pharmacy
576 Pharmacist, Nutrition Support
577 Pharmacist, Pharmacotherapy
578 Pharmacist, Psychopharmacy
580 Physical Therapist
581 Physical Therapist, Cardiopulmonary
583 Physical Therapist, Electrophysiology, Clinical
582 Physical Therapist, Ergonomics
584 Physical Therapist, Geriatrics
585 Physical Therapist, Hand
586 Physical Therapist, Human Factors
587 Physical Therapist, Neurology
590 Physical Therapist, Orthopedic
588 Physical Therapist, Pediatrics
589 Physical Therapist, Sports
592 Physician Assistant
593 Physician Assistant, Medical
594 Physician Assistant, Surgical
596 Psychologist
597 Psychologist, Addiction (Substance Use Disorder)
598 Psychologist, Adult Development & Aging
599 Psychologist, Behavioral
602 Psychologist, Child, Youth & Family
600 Psychologist, Clinical
601 Psychologist, Counseling
603 Psychologist, Educational
604 Psychologist, Exercise & Sports
605 Psychologist, Family
606 Psychologist, Forensic
607 Psychologist, Health
608 Psychologist, Men & Masculinity
609 Psychologist, Mental Retardation & Developmental Disabilities
610 Psychologist, Psychoanalysis
611 Psychologist, Psychotherapy
612 Psychologist, Psychotherapy, Group
613 Psychologist, Rehabilitation
614 Psychologist, School
615 Psychologist, Women
672 Registered Nurse
673 Registered Nurse, Addiction (Substance Use Disorder)
674 Registered Nurse, Administrator
711 Registered Nurse, Ambulatory Care
681 Registered Nurse, Cardiac Rehabilitation
676 Registered Nurse, Case Management
677 Registered Nurse, College Health
678 Registered Nurse, Community Health
680 Registered Nurse, Continence Care
679 Registered Nurse, Continuing Education/Staff Development
675 Registered Nurse, Critical Care Medicine
682 Registered Nurse, Diabetes Educator
683 Registered Nurse, Dialysis, Peritoneal
684 Registered Nurse, Emergency
685 Registered Nurse, Enterostomal Therapy
686 Registered Nurse, Flight
688 Registered Nurse, Gastroenterology
687 Registered Nurse, General Practice
689 Registered Nurse, Gerontology
691 Registered Nurse, Hemodialysis
690 Registered Nurse, Home Health
692 Registered Nurse, Hospice
694 Registered Nurse, Infection Control
693 Registered Nurse, Infusion Therapy
695 Registered Nurse, Lactation Consultant
696 Registered Nurse, Maternal Newborn
697 Registered Nurse, Medical-Surgical
699 Registered Nurse, Neonatal Intensive Care
700 Registered Nurse, Neonatal, Low-Risk
701 Registered Nurse, Nephrology
702 Registered Nurse, Neuroscience
698 Registered Nurse, Nurse Massage Therapist (NMT)
703 Registered Nurse, Nutrition Support
719 Registered Nurse, Obstetric, High-Risk
720 Registered Nurse, Obstetric, Inpatient
721 Registered Nurse, Occupational Health
722 Registered Nurse, Oncology
725 Registered Nurse, Ophthalmic
724 Registered Nurse, Orthopedic
726 Registered Nurse, Ostomy Care
723 Registered Nurse, Otorhinolaryngology & Head-Neck
704 Registered Nurse, Pain Management
706 Registered Nurse, Pediatric Oncology
705 Registered Nurse, Pediatrics
710 Registered Nurse, Perinatal
714 Registered Nurse, Plastic Surgery
708 Registered Nurse, Psych/Mental Health
709 Registered Nurse, Psych/Mental Health, Adult
707 Registered Nurse, Psych/Mental Health, Child & Adolescent
712 Registered Nurse, Rehabilitation
713 Registered Nurse, Reproductive Endocrinology/Infertility
715 Registered Nurse, School
716 Registered Nurse, Urology
718 Registered Nurse, Women's Health Care, Ambulatory
717 Registered Nurse, Wound Care
617 Respiratory Therapist, Certified
618 Respiratory Therapist, Certified, Critical Care
620 Respiratory Therapist, Certified, Educational
619 Respiratory Therapist, Certified, Emergency Care
622 Respiratory Therapist, Certified, General Care
621 Respiratory Therapist, Certified, Geriatric Care
623 Respiratory Therapist, Certified, Home Health
628 Respiratory Therapist, Certified, Neonatal/Pediatrics
627 Respiratory Therapist, Certified, Palliative/Hospice
629 Respiratory Therapist, Certified, Patient Transport
624 Respiratory Therapist, Certified, Pulmonary Diagnostics
626 Respiratory Therapist, Certified, Pulmonary Function Technologist
625 Respiratory Therapist, Certified, Pulmonary Rehabilitation
630 Respiratory Therapist, Certified, SNF/Subacute Care
631 Respiratory Therapist, Registered
632 Respiratory Therapist, Registered, Critical Care
634 Respiratory Therapist, Registered, Educational
633 Respiratory Therapist, Registered, Emergency Care
636 Respiratory Therapist, Registered, General Care
635 Respiratory Therapist, Registered, Geriatric Care
637 Respiratory Therapist, Registered, Home Health
642 Respiratory Therapist, Registered, Neonatal/Pediatrics
641 Respiratory Therapist, Registered, Palliative/Hospice
643 Respiratory Therapist, Registered, Patient Transport
638 Respiratory Therapist, Registered, Pulmonary Diagnostics
640 Respiratory Therapist, Registered, Pulmonary Function Technologist
639 Respiratory Therapist, Registered, Pulmonary Rehabilitation
644 Respiratory Therapist, Registered, SNF/Subacute Care
646 Social Worker, Clinical
648 Specialist/Technologist, Other, Biomedical Engineering
506 Speech-Language Pathologist
649 Technician, Other, Biomedical Engineering
502 Other, Not Listed

For 20201001 BOD Review Only

Code Lists

Specialty Boards - Allied Providers

940 Academy of Certified Social Workers
1150 ACNM Certification Council
360 American Academy of Ambulatory Care Nursing
1550 American Academy of Anesthesiologist Assistants
230 American Academy of Audiology
370 American Academy of Experts in Traumatic Stress
270 American Academy of Health Providers in the Addictive Disorders
200 American Academy of Medical Acupuncture
405 American Academy of Nurse Practitioners
380 American Academy of Nursing
1330 American Academy of Optometry
1480 American Academy of Physician Assistants
1110 American Association for Marriage and Family Therapy
390 American Association of Critical Care Nurses
1590 American Association of Nurse Anesthetists
330 American Association of Pastoral Counselors
1010 American Association of Sex Educators, Counselors and Therapists
710 American Board Medical Psychotherapists
280 American Board of Addiction Medicine
950 American Board of Examiners in Clinical Social Work
720 American Board of Medical Psyhotherapists & Psychodiagnosticians
400 American Board of Nursing Specialties
1240 American Board of Nutrition
1300 American Board of Occupational Medicine
1360 American Board of Ophthalmology
1510 American Board of Physical Therapy Specialties
700 American Board of Professional Psychology
1130 American Naturopath Certification Board
350 American Nurses Credentialing Center
740 American Psychological Association
750 American Psychological Society
760 American Psychotherapy Association
290 American Society of Addiction Medicine
1650 American Speech-Language-Hearing Association
250 Biofeedback Certification Institute of America
1430 Board of Pharmaceutical Specialties
1250 Commission on Dietetic Registration
960 Employee Assistance Professionals Association
780 National Association for the Advancement of Psychoanalysis
1450 National Association of Boards of Pharmacy
1600 National Association of Nurse Anesthetists
770 National Association of School Psychologists
980 National Association of Social Workers
1310 National Board for Certification in Occupational Therapy
1490 National Board for Certification of Orthopaedic Physician Assistants
790 National Board for Certified Clinical Hypnotherapists
310 National Board for Certified Counselors
1630 National Board for Respiratory Care
300 National Board of Addiction Examiners
800 National Board of Cognitive Behavioral Therapists
1350 National Board of Examiners in Optometry
1090 National Certification Board for Therapeutic Massage and Bodywork
210 National Certification Commission for Acupuncture and Oriental Medicine
1440 National Institute for Standards in Pharmacist Credentialing
220 Other - Not Listed

Specialty Boards - MD / DDS / DMD / DO / DPM

MD Boards

044 American Board of Allergy & Immunology
045 American Board of Anesthesiology
046 American Board of Colon & Rectal Surgery
047 American Board of Dermatology
048 American Board of Emergency Medicine
049 American Board of Family Medicine
050 American Board of Internal Medicine
051 American Board of Medical Genetics
052 American Board of Neurological Surgery
053 American Board of Nuclear Medicine
054 American Board of Obstetrics & Gynecology
055 American Board of Ophthalmology
109 American Board of Oral & Maxillofacial Surgeons
056 American Board of Orthopedic Surgery
057 American Board of Otolaryngology
058 American Board of Pathology
059 American Board of Pediatrics
060 American Board of Physical Medicine & Rehabilitation
061 American Board of Plastic Surgery
062 American Board of Preventive Medicine
063 American Board of Psychiatry & Neurology
064 American Board of Radiology
065 American Board of Surgery
066 American Board of Thoracic Surgery
067 American Board of Urology
142 Boards other than ABMS/AOA

Dental Boards

113 American Board of Endodontics
114 American Board of Oral & Maxillofacial Pathology
117 American Board of Oral & Maxillofacial Radiology
109 American Board of Oral & Maxillofacial Surgeons
108 American Board of Orthodontics
112 American Board of Pediatric Dentistry
111 American Board of Periodontology
115 American Board of Prosthodontics
106 American Board of Public Health Dentistry
120 Boards other than ABMS/AOA

DO Boards

118 American Osteopathic Board of Anesthesiology
119 American Osteopathic Board of Dermatology
120 American Osteopathic Board of Emergency Medicine
121 American Osteopathic Board of Family Practice
123 American Osteopathic Board of Internal Medicine
124 American Osteopathic Board of Neurology and Psychiatry
125 American Osteopathic Board of Neuromuskuloskeletal Medicine
126 American Osteopathic Board of Nuclear Medicine
127 American Osteopathic Board of Obstetrics and Gynecology
128 American Osteopathic Board of Ophthalmology and Otolaryngology
129 American Osteopathic Board of Orthopedic Surgery
130 American Osteopathic Board of Pathology
131 American Osteopathic Board of Pediatrics
132 American Osteopathic Board of Preventive Medicine
133 American Osteopathic Board of Proctology
134 American Osteopathic Board of Radiology
135 American Osteopathic Board of Rehabilitation Medicine
136 American Osteopathic Board of Surgery

DPM Boards

140 American Board of Medical Specialists in Podiatry
137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
138 American Board of Podiatric Surgery
139 American Council of Certified Podiatric Surgeons and Physicians

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HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine. **OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. **OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**
3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

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Continue to the Next Page for Attestation Questions

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ◯ Yes ◯ No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ◯ Yes ◯ No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs), or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ◯ Yes ◯ No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ◯ Yes ◯ No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ◯ Yes ◯ No

6. Have you ever been denied certification/recertification by a specialty board? ◯ Yes ◯ No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ◯ Yes ◯ No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ◯ Yes ◯ No
   b. Are any such actions pending? ◯ Yes ◯ No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If **YES**, please complete Addendum B. ◯ Yes ◯ No

10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If **YES**, please complete Addendum B. ◯ Yes ◯ No

11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ◯ Yes ◯ No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **YES**, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ◯ Yes ◯ No

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Continue to the Next Page for Additional Attestation Questions

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. ◯ Yes ◯ No

    If **YES**, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ◯ Yes ◯ No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ◯ Yes ◯ No

15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ◯ Yes ◯ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable) | **PRINTED NAME** | **DATE**

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Continue to the Next Page for Information Release/ Acknowledgements

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.

The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of your application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correct will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

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Healthcare Organization's Credentialing Department Address:

Address:	505 City Parkway West				
City:	Orange	ST:	CA	Zip:	92868

APPLICANT SIGNATURE (Stamp is Not Acceptable) ✖

PRINTED NAME ✖

DATE ✖

Policy:	GG.1633Δ
Title:	**Board Certification Requirements for Physicians**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	
Effective Date:	01/01/2008
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administration

For 20201001BOD Review Only

I. PURPOSE

This policy describes CalOptima's requirement for ~~Board Certification~~board certification of contracted physicians.

II. POLICY

A. A contracted physician shall be board certified within five (5) years following the date upon which that contracted physician completes his or her residency, with the exception of any contracted physician whose board certification time requirement is shorter or longer than the foregoing in which case such shorter or longer period shall apply. For example, a contracted podiatric physician shall be board certified within seven (7) years following the date upon which that contracted podiatric physician completes his or her residency.

B. A physician may be grandfathered and exempt from the requirements of this Policy if all of the following apply:

1. The physician was first licensed to practice medicine in a United States jurisdiction before January 1, 2008; and

2. The physician was a contracted physician with CalOptima or a Health Network prior to July 1, 2016; and

3. The physician's contract with CalOptima or the Health Network did not lapse or terminate for any reason.

C. If a physician's contract with CalOptima or a Health Network lapsed or terminated for any reason, as set forth in Section II.B. above, then the physician is considered a new physician and is not grandfathered for board certification purposes. In these cases, the physician must apply for a new contract and credentialed status and must meet all the requirements of CalOptima Policy GG.1643: Minimum Physician Standards, including without limitation, the board certification requirement.

D. Except as provided in Section II.B. of this Policy, a contracted physician who is required to be board certified shall, at all times, maintain that status in order to participate in CalOptima programs.

Back to Agenda Back to Item

E. A contracted physician shall meet Credentialing and Recredentialing requirements, in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

F. A Health Network shall establish policies and procedures for ~~Board Certification~~board certification of contracted physicians that, at minimum, meet and verify compliance with the requirements as outlined in this Policy.

III. PROCEDURE

A. A contracted physician shall indicate his or her ~~Board Certification~~board certification status as part of the Credentialing and Recredentialing process.

B. CalOptima shall independently verify that a contracted physician is either currently ~~Board Certified,~~board certified or exempt from the ~~Board Certification~~board certification requirements of this policy.

C. Board Certification Entities

1. CalOptima recognizes board certifications from the following board certification entities:

   a. American Board of Medical Specialties (ABMS);

   b. American Medical Association (AMA);

   c. American Osteopathic Association (AOA);

   d. American Board of Foot and Ankle Surgery (ABFAS); and

   e. American Board of Podiatric Medicine (ABPM).

2. CalOptima credentialing team shall obtain annual written confirmation from ABFAS and ABPM that they perform primary source verification of completing of education and training.

3. CalOptima shall use any of the following to verify board certifications for physicians:

   a. For ABMS, a dated certificate of primary-source authenticity.

   b. AMA physician masterfile;

   c. AOA official osteopathic physician profile report or AOA physician masterfile.

   d. ABFAS verification report.

   e. ABPM verification report.

~~C.~~D. If, at any time, CalOptima finds that a contracted physician has failed to maintain his or her board certification as required by this Policy, CalOptima shall notify the contracted physician of his or her noncompliance with the requirements of this Policy and shall require the contracted physician to demonstrate within thirty (30) calendar days after receipt of notice from CalOptima that he or she is actually board certified.

~~D.~~E. If the contracted physician fails to demonstrate within thirty (30) calendar days after receipt of notice from CalOptima that he or she is board certified as required by this Policy, then CalOptima

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will terminate the contract within sixty (60) calendar days and upon appropriate notice to ~~members~~Members, provide notice to the contracted physician that he or she is no longer eligible to participate in CalOptima programs, and reassign any affected ~~members.~~ Members.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

~~A. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing~~
~~B.~~A. CalOptima Policy GG.1643: Minimum Physician Standards
~~C.~~B. CalOptima Policy ~~MA.1001: Glossary~~GG.1650Δ: Credentialing and Recredentialing of ~~Terms~~Practitioners
~~D.~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~E.~~D. NCQA Standards and Guidelines

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
08/10/2017	Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting
06/05/2007	Regular Meeting of the CalOptima Board of Directors
08/07/2007	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW HISTORY

Version	Date	Policy	Policy Title	Program(s)
Effective	01/01/2008	GG.1633	Board Certification Requirements for Physicians	Medi-Cal
Revised	03/01/2013	GG.1633	Board Certification Requirements for Physicians	Medi-Cal
Revised	08/01/2015	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2017	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Health Network	A Physician Hospital Consortium (PHC), pPhysician mMedical gGroup ~~(PMG)~~ under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima program.
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.

For 20201001 BOD Review Only

Policy:	GG.1633Δ
Title:	**Board Certification Requirements for Physicians**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	
Effective Date:	01/01/2008
Revised Date:	
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For 20201001 BOD Review Only

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3. The physician's contract with CalOptima or the Health Network did not lapse or terminate for any reason.

C. If a physician's contract with CalOptima or a Health Network lapsed or terminated for any reason, as set forth in Section II.B. above, then the physician is considered a new physician and is not grandfathered for board certification purposes. In these cases, the physician must apply for a new contract and credentialed status and must meet all the requirements of CalOptima Policy GG.1643: Minimum Physician Standards, including without limitation, the board certification requirement.

D. Except as provided in Section II.B. of this Policy, a contracted physician who is required to be board certified shall, at all times, maintain that status in order to participate in CalOptima programs.

Back to Agenda Back to Item

E. A contracted physician shall meet Credentialing and Recredentialing requirements, in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

F. A Health Network shall establish policies and procedures for board certification of contracted physicians that, at minimum, meet and verify compliance with the requirements as outlined in this Policy.

III. PROCEDURE

A. A contracted physician shall indicate his or her board certification status as part of the Credentialing and Recredentialing process.

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   e. ABPM verification report.

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E. If the contracted physician fails to demonstrate within thirty (30) calendar days after receipt of notice from CalOptima that he or she is board certified as required by this Policy, then CalOptima will terminate the contract within sixty (60) calendar days and upon appropriate notice to Members,

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provide notice to the contracted physician that he or she is no longer eligible to participate in CalOptima programs, and reassign any affected Members.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Policy GG.1643: Minimum Physician Standards
B. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
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. NCQA Standards and Guidelines

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
08/10/2017	Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting
06/05/2007	Regular Meeting of the CalOptima Board of Directors
08/07/2007	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW HISTORY

Version	Date	Policy	Policy Title	Program(s)
Effective	01/01/2008	GG.1633	Board Certification Requirements for Physicians	Medi-Cal
Revised	03/01/2013	GG.1633	Board Certification Requirements for Physicians	Medi-Cal
Revised	08/01/2015	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2017	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE

For 20201001 BOD Review Only

IX. GLOSSARY

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Health Network	A Physician Hospital Consortium (PHC), physician medical group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima program.
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.

For 20201001 BOD Review Only

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Approve proposed revisions to CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities; and
2. Authorize the Chief Executive Officer to implement the policy with reflected revisions.

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. Staff participation provides opportunities to conduct outreach and education about CalOptima's programs and services to current and potential members. Additionally, upon request, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, is 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. This participation may be, for example, through registration fees or financial sponsorship, or may be through in-kind contributions, such as providing branded items. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Policy AA.1223: *Participation in Community Events by External Entities* was approved by CalOptima's Board of Directors on February 2, 2017. This policy establishes the guidelines staff use for participation in community events, programs, projects and activities involving external entities; it also sets parameters for when Board approval is required (e.g., in situations when the level of requested financial participation exceeds a per event or per fiscal year cumulative total). Additionally, the policy attachments include forms used by staff to document requests received and adherence to policy criteria. These activities, through this policy, support CalOptima's 2020-2022 Strategic Plan Strategic Priority of Strengthening Community Partnerships.

Discussion

CalOptima has an annual policy review process by which Policies and Procedures are updated and implemented to comply with new laws, regulations, guidelines, programs or business practices. Pursuant to the annual review process, CalOptima staff proposes revisions to Policy AA. 1223: *Participation in Community Events Involving External Entities* to ensure alignment with current operational practices and regulatory requirements. CalOptima staff recommends updating Policy Attachment B: *Public Activity Transmittal Form* to incorporate questions to facilitate determination of whether Board action is required, either for the particular event, or if the cumulative total funding

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request for the current fiscal year exceeds the limit as stated in the policy. There are no other substantive recommended changes to the policy.

Fiscal Impact

The recommended action for the Board to approve revisions to CalOptima Policy AA.1223 is operational in nature, and no additional fiscal impact beyond what is incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget is anticipated.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support activities that provide opportunities for CalOptima to collaborate and strengthen relationships with community partners. Participation in these activities supports CalOptima's mission, encourage broader participation in CalOptima's programs and services, and promote health and wellness. The proposed revisions to Attachment B: *Public Activity Transmittal Form* that accompanies Policy AA.1223 will facilitate compliance with policy requirements.

Concurrence

Attachment

1. CalOptima Policy AA.1223: Participation in Community Events by External Entities with Attachments (redline and clean)

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

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Policy:	AA.1223
Title:	**Participation in Community Events by External Entities**
Department:	CalOptima Administrative
Section:	Strategic Development, Community Relations
Interim CEO Approval:	
Effective Date:	02/02/2017
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

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I. PURPOSE

This policy establishes guidelines for CalOptima's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CalOptima recognizes the value of partnering with external entities to provide additional health care related services of benefit to the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima's Participation in community events involving external entities, financially, or otherwise, shall be approved only if:

1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare; and

3. In accordance with this Policy.

B. An external entity may be eligible for CalOptima's Participation in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CalOptima members, or supports CalOptima's mission. Religious organizations are not eligible for CalOptima's Participation unless the event is open to the general public and is for a non- sectarian purpose.

C. The expenditure of CalOptima's funds shall only be made for a direct and primary public purpose within CalOptima's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima's authority and jurisdiction, CalOptima shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima's Participation in any manner to

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donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

D. CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative;

2. A presentation, or panel presentation, by a CalOptima representative;

3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members and/or potential members who could be enrolled in any of CalOptima's programs; or

4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way, etc.), may be permitted based on a finding by the CalOptima Board of Directors that the request for financial Participation falls within CalOptima's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides; or

2. There is an identifiable benefit to CalOptima and/or its members.

F. The expenditure of CalOptima funds and the use of resources, staff time, and CalOptima facilities shall not be inconsistent with, or in conflict with, CalOptima's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO), or his/her designee, is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself,

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day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CalOptima's Participation in the event.

2. Requests for financial Participation, up to and including, a cumulative value of one thousand dollars ($1,000) per organization per fiscal year, which shall include all materials and supplies:

   a. Requests for financial Participation in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

   b. The CEO, or his/her designee, is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including one thousand dollars ($1,000) per organization per fiscal year, subject to availability of budgeted funds.

   c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

      i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

      ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

   d. The CEO, or his/her designee, is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

   e. The CEO, or his/her designee, will report all approved Participation in events involving financial Participation in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year to the CalOptima Board of Directors in the CEO's regular Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than one thousand dollars ($1,000) per organization per fiscal year:

   a. Requests for financial Participation for the amount of more than one thousand dollars ($1,000) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

   b. Financial requests from qualified external entities for eligible events valued at more than one thousand dollars ($1,000) require approval from the CalOptima Board of Directors and a

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finding that such financial Participation is in the public good, subject to availability of budgeted funds, and within CalOptima's authority and statutory purpose.

c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's program, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

d. The CEO, or his/her designee, is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

e. The CEO, or his/her designee, will report all approved Participation in events involving financial Participation in amounts more than one thousand dollars ($1,000) per organization per fiscal year to the CalOptima Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of CalOptima's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima staff time (*e.g.*, in their capacity as a CalOptima employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima resources (*e.g.*, CalOptima facilities);

c. The use of current, or future, CalOptima eligible funds; and

d. The value of items donated with the CalOptima master brand/logo.

H. In no event shall approval of CalOptima's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima's name, or logo, in any material by an external entity shall be governed by CalOptima Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima's Name and Logo.

I. The CEO, or his/her designee, shall report any Participation approved by the CEO to the CalOptima Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO, or his/her designee, shall provide members of the CalOptima Board of Directors with advanced notice so they have the opportunity to attend events in which CalOptima Participates.

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K. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid, according to CalOptima Policy GA.5004: Travel Policy to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima pay, or reimburse, a CalOptima employee for expenses arising from personal expenses, political campaigns, or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

L. In the event CalOptima's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Policy MA.2002: Marketing Activity Standards.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima's programs/lines of business, mission, values, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for CalOptima's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed

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request;

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be so notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima's Community Relations Department shall:

1. Notify the requesting entity of CalOptima's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Logo:

1. Requests shall be submitted to CalOptima's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima master logo, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO), or his/her designee, for approval of a donation of items valued at five dollars ($5), or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

A. CalOptima Public Activity Participation Request Form
B. CalOptima Public Activity Transmittal Form

V. REFERENCE(S)

A. California Constitution Article 16, §6
B. California Government Code, §8314
~~C. CalOptima Policy AA.1000: Glossary of Terms~~
~~D.~~C. CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo

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~~E.~~D. CalOptima Policy GA.5004: Travel Policy
~~F.~~E. CalOptima Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVAL

None to Date

VII. BOARD ACTION

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	02/02/2017	AA.1223	Participation in Community Events By External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events By External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events By External Entities	Administrative
Revised		AA.1223	Participation in Community Events By External Entities	Administrative

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IX. GLOSSARY

Term	Definition
Endorsement	The support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	Any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and Participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima.
Participate/ Participation	For purposes of this policy this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose.

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Policy:	AA.1223
Title:	**Participation in Community Events by External Entities**
Department:	CalOptima Administrative
Section:	Strategic Development, Community Relations
Interim CEO Approval:	
Effective Date:	02/02/2017
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

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I. PURPOSE

This policy establishes guidelines for CalOptima's Participation in community events, programs, projects, and activities involving external entities.

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1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare; and

3. In accordance with this Policy.

B. An external entity may be eligible for CalOptima's Participation in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CalOptima members, or supports CalOptima's mission. Religious organizations are not eligible for CalOptima's Participation unless the event is open to the general public and is for a non- sectarian purpose.

C. The expenditure of CalOptima's funds shall only be made for a direct and primary public purpose within CalOptima's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima's authority and jurisdiction, CalOptima shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima's Participation in any manner to

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donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

D. CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative;

2. A presentation, or panel presentation, by a CalOptima representative;

3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members and/or potential members who could be enrolled in any of CalOptima's programs; or

4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way, etc.), may be permitted based on a finding by the CalOptima Board of Directors that the request for financial Participation falls within CalOptima's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides; or

2. There is an identifiable benefit to CalOptima and/or its members.

F. The expenditure of CalOptima funds and the use of resources, staff time, and CalOptima facilities shall not be inconsistent with, or in conflict with, CalOptima's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima in an event proposed by an external entity shall require approval as follows:

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b. The Chief Executive Officer (CEO), or his/her designee, is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself,

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day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CalOptima's Participation in the event.

2. Requests for financial Participation, up to and including, a cumulative value of one thousand dollars ($1,000) per organization per fiscal year, which shall include all materials and supplies:

   a. Requests for financial Participation in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

   b. The CEO, or his/her designee, is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including one thousand dollars ($1,000) per organization per fiscal year, subject to availability of budgeted funds.

   c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

      i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

      ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

   d. The CEO, or his/her designee, is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

   e. The CEO, or his/her designee, will report all approved Participation in events involving financial Participation in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year to the CalOptima Board of Directors in the CEO's regular Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than one thousand dollars ($1,000) per organization per fiscal year:

   a. Requests for financial Participation for the amount of more than one thousand dollars ($1,000) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

   b. Financial requests from qualified external entities for eligible events valued at more than one thousand dollars ($1,000) require approval from the CalOptima Board of Directors and a

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finding that such financial Participation is in the public good, subject to availability of budgeted funds, and within CalOptima's authority and statutory purpose.

c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's program, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

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e. The CEO, or his/her designee, will report all approved Participation in events involving financial Participation in amounts more than one thousand dollars ($1,000) per organization per fiscal year to the CalOptima Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of CalOptima's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima staff time (*e.g.*, in their capacity as a CalOptima employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima resources (*e.g.*, CalOptima facilities);

c. The use of current, or future, CalOptima eligible funds; and

d. The value of items donated with the CalOptima master brand/logo.

H. In no event shall approval of CalOptima's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima's name, or logo, in any material by an external entity shall be governed by CalOptima Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima's Name and Logo.

I. The CEO, or his/her designee, shall report any Participation approved by the CEO to the CalOptima Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO, or his/her designee, shall provide members of the CalOptima Board of Directors with advanced notice so they have the opportunity to attend events in which CalOptima Participates.

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K. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid, according to CalOptima Policy GA.5004: Travel Policy to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima pay, or reimburse, a CalOptima employee for expenses arising from personal expenses, political campaigns, or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

L. In the event CalOptima's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Policy MA.2002: Marketing Activity Standards.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima's programs/lines of business, mission, values, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for CalOptima's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed

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request;

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be so notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima's Community Relations Department shall:

1. Notify the requesting entity of CalOptima's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Logo:

1. Requests shall be submitted to CalOptima's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima master logo, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO), or his/her designee, for approval of a donation of items valued at five dollars ($5), or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

A. CalOptima Public Activity Participation Request Form
B. CalOptima Public Activity Transmittal Form

V. REFERENCE(S)

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo
D. CalOptima Policy GA.5004: Travel Policy

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E. CalOptima Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVAL

None to Date

VII. BOARD ACTION

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	02/02/2017	AA.1223	Participation in Community Events By External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events By External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events By External Entities	Administrative
Revised		AA.1223	Participation in Community Events By External Entities	Administrative

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IX. GLOSSARY

Term	Definition
Endorsement	The support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	Any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and Participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima.
Participate/ Participation	For purposes of this policy this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose.

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Public Activity Participation Request Form

Requesting Entity:				
Requesting Entity's Principal Office/ Base Operations Location:				
How long Requesting Entity has been operating:				
Requesting Entity's service areas:				
Description of relationship between Requesting Entity's work/event and CalOptima's lines of business, mission, values, and/or purpose:				
Description, background and pertinent information (eg. Members of Board of Directors) and other entities with a substantial role in event:				
List of individuals or entities supporting the event:				
Entity Type:	☐ Non-Profit Org	☐ For-Profit Org	☐ Religious Org	☐ Health Care Partner

Section I: Event Details			
Name:			
Day/Date:			
Start Time:		**End Time:**	
Location:			
City:		**Zip Code:**	
POC Name:			
Phone#:		**Fax #:**	
Email:			
Type of Event	☐1 Opportunity to outreach to members or potential members		
	☐2 Opportunity to outreach to health care professionals, non-profit orgs or policy-makers		
	☐3 Other:		
Expected # of Attendees:			

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Public Activity Participation Request Form

Section II: About the Attendees (check all that apply)				
Primary Language Spoken:	☐ English	☐ Spanish	☐ Vietnamese	☐ Other:

Event for:	☐ Children	☐ Persons with disabilities
	☐ Low-income families	☐ General public
	☐ Low-income older adults/seniors	☐ Other:

Event for CalOptima LOB:	☐ OC/OCC	☐ PACE	☐ Medi-Cal

Section III: Cost to CalOptima to Participate		
Registration Fee:	☐ No	☐ Yes, amount:
Sponsorship Request:	☐ No	☐ Yes, amount:

Section IV: Notes/Comments

Section V: Disclosures

Requests must be submitted to the Community Relations Department: Staff Participation 14 days in advance; Financial Participation at or under $1,000 21 days in advance; Financial Participation more than $1,000 60 days in advance.

*****All event materials/information must be attached*****

Public Activity Transmittal Form

Please complete your portion of this form and route it in the order indicated below. Please contact Lisa ~~a~~ Nguyen at ext. 8809 if you have any questions.

Today's Date: _____ **Complete Routing By:** _____

Routing Order			
1. Department POC:		**Complete Review By:**	
2. Department POC:		**Complete Review By:**	
3. Department POC:		**Complete Review By:**	

For CR Use Only: CR Initial Review

Requests for CalOptima's Participation in community events involving external entities must be:

1 .	Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.	☐ Yes	☐ No
2.	Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of health care; and	☐ Yes	☐ No
3 .	In accordance with Policy AA.1223: Participation in Community Events Involving External Entities	☐ Yes	☐ No

CalOptima's Participation shall include at least one (1) of the following:

1.	A speaking opportunity for a CalOptima representative	☐ Yes	☐ No
2.	A presentation, or panel presentation, by a CalOptima representative	☐ Yes	☐ No
3.	A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members/potential members	☐ Yes	☐ No
4 .	Other opportunity to promote CalOptima's services and increase awareness about CalOptima	☐ Yes	☐ No

Financial Participation must meet one (1) of the following criteria, if applicable:

1 .	The financial participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides	☐ Yes	☐ No
2.	There is an identifiable benefit to CalOptima and/or its members	☐ Yes	☐ No

Board of Directors Approval Required if an Entity Exceeds the $1,000 per Fiscal Year Limit: ~~one (1) of the following criteria is met~~

~~1.~~1.	Is the requesting entity acting as the fiscal agent?	☐ Yes	☐ No
2.	Has CalOptima provided prior financial sponsorship to the requesting entity within the current fiscal year?	☐ Yes	☐ No
3.	Does the cumulative t~~T~~otal for this FY ~~financial sponsorship provided to requesting entity within current fiscal year~~ exceed the~~s~~ $1,000 limit per entity, which requires Board approval?	☐ Yes	☐ No
4.	If yes, then d~~D~~ate of Board of Directors' approval~~:, if applicable~~		

Other considerations:

Process as an Endorsement (i.e. policy AA.1214)	☐ Yes	☐ No

Public Activity Transmittal Form

Event affiliated with a member of the Board, MAC, PAC, or Employee	☐ Yes	☐ No
Request Legal Review (i.e. conflict analysis)	☐ Yes	☐ No
Included in budget	☐ Yes, amount	☐ No
CalOptima participated in the past	☐ Yes, year(s)	☐ No

Notes:

CR Participation Commitment:	**YES**	**NO**	**NA**
Assume "Lead Department" role	☐ Staff:	☐	☐
Assume "Support Department" role	☐ Staff:	☐	☐
Provide financial support (i.e. registration fee, sponsorship, etc.)	☐ Amount:	☐	☐
Provide promotional items	☐	☐	☐
Provide brochures/educational materials	☐	☐	☐
Other:	☐ Specify:	☐	☐

Note:

Signature Required Only for Sponsorships, Endorsements and Registration Fees.

Date:

Tiffany Kaaiakamanu, Manager of Community Relations

***CalOptima's CEO has delegated authority to approve requests for financial participation in an amount up to and including $1,000 if it is determined that CalOptima's participation is of public purpose.**

Public Activity Transmittal Form

Please complete your portion of this form and route it in the order indicated below. Please contact Lisa Nguyen at ext. 8809 if you have any questions.

Today's Date: _____ **Complete Routing By:** _____

Routing Order			
1. Department POC:		**Complete Review By:**	
2. Department POC:		**Complete Review By:**	
3. Department POC:		**Complete Review By:**	

For CR Use Only: CR Initial Review

Requests for CalOptima's Participation in community events involving external entities must be:

1.	Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.	☐ Yes	☐ No
2.	Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of health care; and	☐ Yes	☐ No
3.	In accordance with Policy AA.1223: Participation in Community Events Involving External Entities	☐ Yes	☐ No

CalOptima's Participation shall include at least one (1) of the following:

1.	A speaking opportunity for a CalOptima representative	☐ Yes	☐ No
2.	A presentation, or panel presentation, by a CalOptima representative	☐ Yes	☐ No
3.	A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members/potential members	☐ Yes	☐ No
4.	Other opportunity to promote CalOptima's services and increase awareness about CalOptima	☐ Yes	☐ No

Financial Participation must meet one (1) of the following criteria, if applicable:

1.	The financial participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides	☐ Yes	☐ No
2.	There is an identifiable benefit to CalOptima and/or its members	☐ Yes	☐ No

Board of Directors Approval Required if an Entity Exceeds the $1,000 per Fiscal Year Limit:

1.	Is the requesting entity acting as the fiscal agent?	☐ Yes	☐ No
2.	Has CalOptima provided prior financial sponsorship to the requesting entity within the current fiscal year?	☐ Yes	☐ No
3.	Does the cumulative total for this FY exceed the $1,000 limit per entity, which requires Board approval?	☐ Yes	☐ No
4.	If yes, then date of Board of Directors approval:		

Other considerations:

Public Activity Transmittal Form

Process as an Endorsement (i.e. policy AA.1214)	☐ Yes	☐ No
Event affiliated with a member of the Board, MAC, PAC, or Employee	☐ Yes	☐ No
Request Legal Review (i.e. conflict analysis)	☐ Yes	☐ No
Included in budget	☐ Yes, amount	☐ No
CalOptima participated in the past	☐ Yes, year(s)	☐ No

Notes:

CR Participation Commitment:	**YES**	**NO**	**NA**
Assume "Lead Department" role	☐ Staff:	☐	☐
Assume "Support Department" role	☐ Staff:	☐	☐
Provide financial support (i.e. registration fee, sponsorship, etc.)	☐ Amount:	☐	☐
Provide promotional items	☐	☐	☐
Provide brochures/educational materials	☐	☐	☐
Other:	☐ Specify:	☐	☐

Note:

Signature Required Only for Sponsorships, Endorsements and Registration Fees.

Date:

Tiffany Kaaiakamanu, Manager of Community Relations

***CalOptima's CEO has delegated authority to approve requests for financial participation in an amount up to and including $1,000 if it is determined that CalOptima's participation is of public purpose.**

This Item is Continued to a Future Meeting

AGENDA ITEM 30

THIS ITEM WILL BE CONSIDERED
AFTER CLOSED SESSION

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Board of Directors Meeting
October 1, 2020

Provider Advisory Committee (PAC) Update

September 10, 2020 PAC Meeting

On September 10, 2020, the Provider Advisory Committee (PAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

Richard Sanchez, Interim Chief Executive Officer, provided a CEO report and notified the committee that at its September 3, 2020 meeting, the Board elected Supervisor Andrew Do as the Chair and Isabel Becerra as the Vice Chair through December 31, 2020.

David Ramirez, M.D., Chief Medical Officer, provided an update on the Department of Health Care Services (DHCS) Pharmacy Portal. He noted that DHCS, in partnership with its Pharmacy Benefits Manager Magellan, has created a comprehensive Medi-Cal RX website and portal. This website and portal are available for providers, including pharmacists, to register for the Medi-Cal Rx program and access necessary training programs. Dr. Ramirez noted that the portal would not go live for actual on-going pharmacy-related issues until January 1, 2021. He also noted that both members and providers would be sent 90,60, and 30-day notices from CalOptima.

Dr. Ramirez notified the PAC members that the Long-Term Care at Home program has been cancelled by DHCS and also discussed the Intergovernmental Transfer (IGT) 9 funding for the Expanded Office Hours Pilot. He noted that this program had been previously approved by the Board, but that after a reevaluation due to COVID-19, it was decided to not move forward at this time with the program. Staff plans to see Board authority at a future meeting to redirect these IGT 9 funds toward virtual care visits.

Michelle Laughlin, Executive Director, Provider Network Operations, provided an update on the health network certification progress for DHCS and Candice Gomez, Executive Director, Program Implementation, provided an update on Intergovernmental Transfer Funds (IGT).

PAC also received the Annual Health Effectiveness Data and Information Set (HEDIS) update, a Federal and State Legislative update and an update from Christine Tolbert, Member Advisory Committee (MAC) Chair, on MAC initiatives for the upcoming year.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

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Board of Directors Meeting
October 1, 2020

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

August 27, 2020 WCM FAC Meeting

OneCare Connect Member Advisory Committee (OCC MAC) welcomed Eleni Hailemariam, M.D., as the Orange County Health Care Agency Representative and also recommended the appointments of Patty Mouton as the OCC MAC Chair and Keiko Gamez as the OCC MAC Vice Chair.

Richard Sanchez, Interim Chief Executive Officer, notified the committee that Orange County has now been removed from the COVID watch list. He notified the committee that the Department of Health Care Services (DHCS) had reached out to CalOptima, indicating it may be making mid-term reductions to the Medi-Cal Expansion rates it pays CalOptima, with the reductions going into effect as soon as January 1, 2021. Mr. Sanchez also noted that the Long-Term Care at Home program that was to begin in 2021 had been cancelled and provided an update on the Pharmacy Carve-Out that will be effective January 1, 2021.

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

OCC MAC received updates from David Ramirez, M.D., Chief Medical Officer, along with a Homeless Health Initiative presentation from Dr. Ramirez and Candice Gomez, Executive Director, Program Implementation, and a Federal and State Legislative Update by TC Roady, Director, Regulatory Affairs. OCC MAC members also received an Annual Healthcare Effectiveness Data and Information Set (HEDIS) Report from Irma Munoz, Sr. Project Manager.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

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Board of Directors Meeting
October 1, 2020

Whole-Child Model Family Advisory Committee (WCM FAC) Update

August 25, 2020 WCM FAC Meeting

Whole-Child Member Family Advisory Committee (WCM FAC) reviewed the FY2020-21 slate of candidates for the Chair and Vice Chair of the WCM FAC. The committee recommends Kristen Rogers for Chair and Brenda Deeley as Vice Chair.

Richard Sanchez, Interim Chief Executive Officer, provided an update on COVID-19 and its impact on the economy overall. His update also included information about the latest developments at the Department of Health Care Services (DHCS), which includes a possible mid-year adjustment to CalOptima's Medi-Cal rates.

Ladan Khamseh, Chief Operating Officer, informed the committee that, during routine regulatory, audit it was determined that a number of Medi-Cal members had been assigned to medical groups rather than to primary care physicians. Each impacted member has been notified and reassigned to the correct primary care physician. Ms. Khamseh also provided an update on the ongoing Qualified Medicare Beneficiary outreach effort to members who meet the criteria for both Medicare Part A and Part B.

WCM FAC received a presentation on the Pharmacy Carve-out by Kristen Gericke, Pharm.D that elicited many questions and concerns from the committee, mostly centered around ensuring that members' access to the medications they need will not be disrupted.

The Committee also received a Chief Medical Officer update from David Ramirez, M.D., a Whole-Child Model update from Thanh-Tam Nguyen, M.D., Medical Director, and a Federal and State Legislative update from TC Roady, Director, Regulatory Affairs.

The WCM FAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the WCM FAC's current activities.

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