NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, NOVEMBER 1, 2018
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Lisa Bartlett, Alternate

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

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. Department of Health Care Services Quality Award
   b. New Chief Medical Officer
   c. Whole-Child Model
   d. Quality Care Ad Campaign
   e. Knox-Keene Health Plan Licensing Regulation Update
   f. Private Hospital Directed Payment Program
   g. CalOptima-Hosted Community Meetings
   h. Program of All-Inclusive Care for the Elderly Letters of Support

PUBLIC COMMENTS

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

CONSENT CALENDAR

2. Consider Approving Minutes of the October 4, 2018 Regular Meeting of the CalOptima Board of Directors

REPORTS

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

4. Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy and Approving Related Scope of Work

5. Consider Authorizing Actions Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services

6. Consider Revisions to Policy FF.1005c: Special Payments: High Cost Exclusion Items

7. Consider Authorizing an Amendment to Amend and Extend the Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency

8. Consider Authorizing Extending the OneCare Physician Medical Group Shared Risk Contracts

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

10. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to Provider Health Network Contracts Except Those Pertaining to the CalOptima Community Network Contracts

11. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Provider Contracts Except Those Associated with St. Joseph Health and the University of California, Irvine

12. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Specialist Provider Contracts Associated with St. Joseph Health

13. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Primary Care Provider Contracts Associated with St. Joseph Health

14. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Mental Health Provider Contracts Associated with St. Joseph Health

15. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Provider Contracts Associated with the University of California, Irvine

16. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2018-19 Capital Budget for the CalOptima Provider Portal Project

17. Consider Ratifying a Revised Amendment to the Primary Agreement with the California Department of Health Care Services

18. Consider Authorizing and Directing the Chairman of the CalOptima Board of Directors to Execute an Amendment to the Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly

19. Consider Authorizing Exploration of CalOptima's Participation in Be Well Orange County

20. Consider Adoption of Resolution to Amend CalOptima's Conflict of Interest Code

21. Consider Authorizing CalOptima to Explore Policy Opportunities to Carve-In Medi-Cal Dental Benefits for CalOptima Medi-Cal Members in Orange County

ADVISORY COMMITTEE UPDATES

22. Joint Report of the Member Advisory Committee, OneCare Connect Member Advisory Committee and Provider Advisory Committee

INFORMATION ITEMS

23. CalOptima Foundation Options

24. September 2018 Financial Summary

25. Compliance Report

26. Federal and State Legislative Advocates Report

27. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, December 6, 2018 at 2:00 p.m.

MEMORANDUM

DATE:	November 1, 2018
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

CalOptima Earns Quality Honor From California Regulators
More excellent news about quality! Adding to our accolades from the National Committee for Quality Assurance (NCQA), CalOptima was honored in October by the Department of Health Care Services (DHCS) with the 2018 Outstanding Performance Award for a Large-Scale Plan. This is the fourth year in a row that CalOptima has received this significant recognition from our regulators. Thank you to your Board for continuously supporting our efforts to be the best we can be for members!

David Ramirez, M.D., Joins CalOptima as Chief Medical Officer (CMO)
On October 29, David Ramirez, M.D., became CalOptima's new CMO. A board-certified internist, Dr. Ramirez brings a diverse background of leadership in clinical and health plan environments as well as a top-notch medical education. He earned his bachelor's degree in biology from Stanford University and his medical degree from Harvard Medical School. Dr. Ramirez completed his residency in Internal Medicine at Cedars-Sinai Medical Center in Los Angeles. Most recently, he worked for six years at Cerritos-based CareMore in positions of increasing responsibility, from Medical Director to Senior Medical Director and finishing as Chief Quality Officer. Prior to CareMore, Dr. Ramirez lived in Austin, Texas, for nearly 10 years where he worked in the ambulatory care and hospital settings.

CalOptima Focused on January 1 Implementation of Whole-Child Model (WCM)
With the transition of the California Children's Services (CCS) program to the WCM just two months away, CalOptima is making final preparations to ensure a positive experience for children, families and providers alike. Please see below for updates.

- *Member Notices*: The October DHCS 90-day notice to more than 13,000 Orange County families generated calls to Customer Service for more information. Staff is also expecting more calls in response to CalOptima's 60-day notice, which was delivered by November 1. One final 30-day notice is planned, as are up to three automated calls per member, starting 60 days prior to the transition.
- *Family Events:* CalOptima's October series of five family events was successful, reaching approximately 80 children and parents. One unique aspect was the involvement of our health networks, which participated as exhibitors to answer questions and engage the attendees. Held in five locations across Orange County with day and evening times, the events featured an overview presentation and a question-and-answer segment.

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- *WCM Family Advisory Committee (WCM FAC) Training:* The Lucile Packard Foundation for Children's Health (LPFCH) has been working with health plans, associations and regulators to ensure a smooth transition. In mid-October, LPFCH hosted an interactive training in Sacramento for WCM FAC members. Two CalOptima staff and Kristen Rogers, a CalOptima WCM FAC representative, attended. The training provided the background and history of CCS, reviewed the Brown Act as it relates to committee work, and helped committee members understand their roles and responsibilities.
- *Stakeholder Engagement:* Keeping community-based organizations and stakeholders up to date about the transition remains a priority. Coming soon on November 7, our CalOptima Informational Series will focus on the transition, including a presentation by Brianna Lierman, CEO of Local Health Plans of California. More than 100 are expected to attend.

Preventive Care Messages Featured in New CalOptima Quality Care Ad Campaign
Starting this month, CalOptima will debut a series of advertisements to highlight the importance of receiving preventive care at all ages, from infancy to golden years. The campaign will feature billboard, bus shelter and print ads in English, Spanish and Vietnamese. The ads also mention our NCQA recognition as the top-rated Medi-Cal plan in California.

Knox-Keene Health Plan Licensing Regulation Update
As an update to Board member comments at the October meeting on the proposed regulation addressing health plan licensing requirements, the regulation was disapproved by the Office of Administrative Law (OAL) on October 15, 2018. The Department of Managed Health Care (DMHC) will have 120 days to address the OAL's concerns related to the proposed rule's lack of clarity regarding the basis and method for obtaining an exemption from the licensure requirement as well as other technical defects. Before the proposed regulation can be resubmitted to the OAL, the proposed regulation must be available for public comment for at least 15 days. Our expectation is that the DMHC's revised regulation will provide clarification on its applicability to our health networks for CalOptima members.

CalOptima Working Alongside Hospitals to Support New Directed Payment Program
CalOptima is partnering with the Hospital Association of Southern California (HASC) to address the state's implementation of the private hospital directed payment program, which replaces the former Quality Assurance Fee. Recent policy guidance from DHCS indicated that, in order for a private hospital to receive supplemental payments for Medi-Cal services, it must have a direct contract with the entity that manages members' encounters. In CalOptima's delegated model, this means that health networks would have to have actual contracts — not just letters of agreements — with all hospitals treating their members. In many cases, those contracts are not yet in place, which could significantly decrease payments. Therefore, CalOptima, HASC, the California Hospital Association (CHA) and the health plan associations came together at an October 9 Sacramento meeting to advocate for flexibility in the DHCS policy so that Orange County hospitals would not be adversely impacted. As a result, DHCS agreed to provide flexibility so hospitals do not lose funding in the interim, and hospitals agreed to pursue direct contracting arrangements with our health networks. Since then, CalOptima has shared this information in an effort to ensure our community receives the maximum funding available to support members.

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CalOptima Welcomes a Variety of Community Partners for October Meetings
Partnership is the common thread running through many CalOptima-hosted meetings. In October, staff engaged three groups of community partners essential to the agency's success.

- *Health Networks:* CalOptima invited health network CEOs to address the key financial topics of rate rebasing and the private hospital directed payment program. Milliman, the actuary on our rate rebasing effort earlier this year, made a follow-up presentation to ensure health networks' understanding of the methodology. Then, a CHA representative presented detailed information about the directed payment program, reinforcing the message from the DHCS meeting described above that health networks and hospitals need direct contracts so the hospitals remain eligible for supplemental payments.
- *Community Health Centers:* At the quarterly Safety Net Summit that brings together members of the Coalition of Orange County Community Health Centers, CalOptima's Director of Quality Analytics Kelly Rex-Kimmett presented information about our recent quality recognitions and the role for community health centers in maintaining quality care.
- *Elected Offices:* More than 50 representatives from elected offices and community-based organizations gathered to learn about our upcoming CCS transition. The presentation was well received as we emphasized our commitment to ensuring continuity of care and improved care coordination for Orange County's medically fragile children.

Program of All-Inclusive Care for the Elderly (PACE) Letter of Support Process Opens
On November 1, CalOptima launched the process for independent PACE organizations to request a letter of support. Such a letter will allow the organization to apply with the state to offer PACE services in Orange County independent of CalOptima. Requests for letters of support will be accepted until January 31, 2019. A document explaining the process was distributed to the community and posted on our website.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

October 4, 2018

A Regular Meeting of the CalOptima Board of Directors was held on October 4, 2018, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Director Penrose led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: Alexander Nguyen, M.D.

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

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader reported that for the fifth year in a row, the National Committee for Quality Assurance (NCQA) rated CalOptima the top health plan in California for the Medi-Cal program, and thanked staff and the provider community for providing CalOptima members with access to quality care delivered in a cost-effective and compassionate manner. Mr. Schrader also noted the January 1, 2019 transition of California Children's Services program to the Whole-Child Model and provided updates on member communications, network operations, and advisory committee support.

Supervisor Do commented on Be Well OC, a coalition working to improve the behavioral health system in Orange County, and CalOptima's involvement in coordination with other stakeholders to further define the goals and establish a communitywide work plan.

PUBLIC COMMENT

Lourdes Alberto, Prospect Medical Group; Dr. Phiet Phung; and Teri Miranti, Monarch HealthCare – Oral re: Agenda Item 9, Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy, Approving Related Scope of Work, and Expansion of Existing Engagement with Milliman, Inc. for Actuarial Services/

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CONSENT CALENDAR

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

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

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 7-0-0; Vice Chair Khatibi and Director Nguyen absent)***

REPORTS

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

As Chair of the Board of Directors' Finance and Audit Committee, Director Penrose reported that the Committee reviewed the audit of CalOptima's FY 2018 financial statements at the September 18, 2018 meeting, and received a detailed presentation of the audit results by Moss-Adams, LLP, CalOptima's financial auditors.

Chief Financial Officer Greg Hamblin reported that the results of CalOptima's FY 2018 were positive and stated that Moss-Adams will issue an unmodified opinion on the financial statements indicating that the FY 2018 financial statements fairly state the financial condition of CalOptima in all material respects.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors accepted and received and filed the Fiscal Year 2018 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP. (Motion carried 7-0-0; Vice Chair Khatibi and Director Nguyen absent)***

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

Director Penrose reported that the Foundation Audit Committee met on September 18, 2018 to review the audit of the CalOptima Foundation's FY 2018 financial statements as presented by Moss-Adams, LLP. The FY 2018 audit results were positive for the CalOptima Foundation and recommended that the Foundation Board of Directors accept and receive and file the audited financial statements as submitted by Moss-Adams, LLP.

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Action: ***On motion of Director Penrose, seconded and carried, the Foundation Board of Directors accepted and received and filed the Fiscal Year 2018 CalOptima Foundation audited financial statements as submitted by independent auditors Moss-Adams, LLP. (Motion carried 7-0-0; Vice Chair Khatibi and Director Nguyen absent)***

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer to revise and develop new Medi-Cal financial policies and procedures in conjunction with the Whole-Child Model program: FF.1007: Health Network Reinsurance Coverage; FF.1009: Health-based Risk Adjusted Capitation Payment System; FF.1010: Shared Risk Pool; and FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks. (Motion carried 7-0-0; Vice Chair Khatibi and Director Nguyen absent)***

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer to modify existing and develop new policies and procedures in connection with the Whole-Child Model initiative as follows: FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group [Medi-Cal]; GG.1101: California Children's Services [Medi-Cal]; GG.1112: Standing Referral to Specialist Provider or Specialty Care Center [Medi-Cal, OneCare, OneCare Connect]; GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transfer into CalOptima [Medi-Cal]; GG.1330: Case Management – California Children's Services Program/Whole Child Model [Medi-Cal]; GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair [Medi-Cal, OneCare, OneCare Connect]; GG.1535: Utilization Review Criteria and Guidelines [Medi-Cal, OneCare, OneCare Connect]; and GG. 1547: Maintenance and Transportation [Medi-Cal]. (Motion carried 7-0-0; Vice Chair Khatibi and Director Nguyen absent)***

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

Supervisor Do suggested continuing the recommended actions pertaining to the RFP for Consulting Services and the related Statement of Work to the November 1, 2018 Board meeting in order to allow input from the Advisory Committees resulting from their Joint Meeting to be held on October 11, 2018.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors continued the following recommended actions to the November 1, 2018 meeting: 1) Authorize the Chief Executive Officer to issue a Request for Proposal for consulting services to***

provide data analysis and to perform a market survey related to the CalOptima provider network delivery system; and 2) Approve the related attached Scope of Work. (Motion carried 8-0-0; Director Nguyen absent)

Director Schoeffel did not participate in the recommended action to authorize the expansion of existing actuarial service engagement with Milliman, Inc., and left the room during the discussion and vote.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the expansion of existing actuarial service engagement with Milliman, Inc. to include the exploration of risk adjustment methodologies that will allow for appropriate comparisons of financial and utilization metrics across different health network types and authorize expenditure of unbudgeted funds in an amount not to exceed $35,000 from reserves for this purpose. (Motion carried 7-0-0; Directors Nguyen and Schoeffel absent)***

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

Supervisor Steel requested that going forward, staff present recommendations regarding the approval and adoption of updated Human Resources Policies for consideration on a quarterly basis.

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors adopted Resolution No. 18-1004, approving updates to Human Resources Policies GA.8032, Employee Dress Code, GA.8032, Employee Dress Code, GA.8050, Confidentiality, and GA.8058, Salary Schedule. (Motion carried 8-0-0; Director Nguyen absent)***

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

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

Supervisor Do requested that staff include performance metrics and appropriate data in recommended actions for contract extensions presented to the Board for consideration.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors ratified the extension of CalOptima's current Pharmacy Benefits Manager Services Agreement with MedImpact Healthcare Systems, Inc., for one year, effective January 1, 2019 through December 31, 2019. (Motion carried 7-0-0; Directors Nguyen and Schoeffel absent)***

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the expenditure of up to $3,500 and staff participation at El Centro Cultural de Mexico's Noche de Altares on Saturday, November 3, 2018, in Downtown Santa Ana between 4th Street and Broadway, made a finding that such expenditure is for a public purpose and in furtherance of CalOptima's mission and statutory purpose, and***

authorized the Chief Executive Officer to execute agreements as necessary for the event and expenditure. (Motion carried 8-0-0; Director Nguyen absent)

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

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors awarded Chief Counsel a merit increased based on the overall rating of fully meets expectations consistent with CalOptima's merit matrix. The recommended merit is calculated as a function of the evaluation score, salary and salary range, and is the same merit matrix and methodology used for all CalOptima employees. (Motion carried 7-0-0; Directors Nguyen and Schoeffel absent)***

ADVISORY COMMITTEE UPDATES

14. Member Advisory Committee (MAC) Update

MAC Chair Sally Molnar reported that the MAC will participate in the joint meeting with the Provider Advisory Committee on October 11, 2018 and will provide recommendations regarding CalOptima's delivery system strategy and auto-assignment limits to the Board at the November 1, 2018 meeting.

15. Provider Advisory Committee Update

Dr. John Nishimoto, PAC Chair, reported that the PAC will join members of the MAC and OneCare Connect Member Advisory Committee on October 11, 2018 to discuss CalOptima's delivery system strategy and proposed changes to the auto-assignment for the CalOptima Community Network. The PAC will provide input at the November 1, 2018 Board of Directors meeting.

INFORMATION ITEMS

16. Intergovernmental Transfer (IGT) Funding Update

Chair Yost thanked staff for the analysis on the IGT funding changes starting with Rate Year 2017-18 (IGT 8) and requested that the Board of Directors' Finance and Audit Committee evaluate the information and return to the Board with further recommendations.

The following Information Items were accepted as presented:
17. August 2018 Financial Summary
18. Compliance Report
19. Federal and State Legislative Advocates Report
20. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Board members extended congratulations to staff and CalOptima's provider partners for achieving NCQA's top quality rating for the fifth year.

Supervisor Do and Director Schoeffel commented on the Mega Reg as it relates to possible requirements for CalOptima's health networks to obtain Knox Keene licenses; the Board directed staff to agendize this item for future consideration.

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Chair Yost reported that at the September 6, 2018 Board meeting, an ad hoc was appointed to review Request for Information responses and make recommendations to the Board related to the expenditure of IGT 5 funds. At that time, Directors Nguyen, Penrose, and Supervisor Do were appointed to serve with him on this ad hoc; to date, the ad hoc has not met. To ensure that there are no conflict of interest issues, the configuration of the ad hoc was changed, and Director DiLuigi was appointed to serve with Supervisor Do on this ad hoc.

Chair Yost also commented on fragmented psychiatric services within the County and how CalOptima and the County of Orange could work together on this issue. Director Sanchez commented on the Orange County Health Care Agency's efforts in the realignment of mental health services.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 3:20 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: November 1, 2018

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Removed from Agenda – 11/1/2018

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

On November 5, 2009, the CalOptima Board of Directors authorized staff to organize a contracted CalOptima Direct Network. This action authorized staff to establish contracts between CalOptima directly with community providers for the delivery of health care services to CalOptima members enrolled in CalOptima Direct.

At its March 6, 2014 meeting, the Board authorized expansion of the Direct Network to include CCN, which would allow participation of a broader range of providers and to supplement the existing delivery system and expand member choice through CCN. CCN expansion was based on the following attributes:

1. Accept any willing and qualified provider;
2. Allow enrollment of any members eligible for health network enrollment;
3. Stop auto-enrollment, excluding assign-back and family link, to CCN when total enrollment reached 10% of CalOptima's overall membership; and
4. Directly contract with independent and group physicians.

At the same meeting, staff reported that CalOptima had and would continue to actively seek stakeholder feedback on the development of CCN. Some of the feedback received from existing health networks was the concern that CCN would compete with the existing networks, that it could create an incentive for physicians to no longer participate with existing networks, and that it might provide an unfair financial advantage for CalOptima, including as it related to funding and provider reimbursement levels. Other providers, including individual physicians, the Member Advisory Committee, and the Orange County Medical Association were supportive of the proposal and provided positive feedback.
CCN has now been in place for several years. The CCN provider network currently includes over 3,000 contracted primary care physicians and specialists in Orange County, with nearly 75,000 assigned members. The 10% auto-assignment was closed effective April 2017, and no new members have been auto-assigned to CCN since that time. However, enrollment in CCN has continued to grow due to member selection. In terms of quality scores, CCN ranks 9th in the group of 13 health networks. Kaiser Foundation Health Plan is not included in the auto-assignment process.

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At its August 2, 2018 meeting, the Board directed staff to provide additional information regarding CCN and include an agenda item that would allow the Board to consider revisions to/removal of the 10% CCN auto-assignment cap. In the event that the Board opts to remove the 10% auto-assignment limit, as proposed, there would be no limit on CCN auto-assignment and enrollment; based on Board policy, the other contracted health networks are individually limited to a maximum of one-third of all CalOptima Members eligible for enrollment.

This Board item was presented at the September 6, 2018 meeting. After discussion of the matter, the Board continued this item to the November 1, 2018 Board meeting. The continuation was proposed to allow staff to solicit input from stakeholders including the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC).

Pursuant to the Board's direction, Management made presentations on the CalOptima delivery system at the MAC and PAC meetings, held separately on September 13, 2018. Both the MAC and PAC recommended holding a special joint meeting on October 11, 2018, with members of the MAC, OneCare Connect (OCC) MAC and PAC to allow for more discussion and public comments from providers and community stakeholders.

On October 11, 2018, MAC and PAC members held a special joint meeting to further discuss the proposed removal of the 10% auto-assignment limit for CCN. After much discussion, including comments from the public, the committees did not support the removal of the 10% CCN auto-assignment limit. The primary reason given for not moving forward with the change included the additional growth in CCN enrollment through member selection even though auto-assignment to CCN has been closed since April 2017. Member choice is the highest priority for Medi-Cal and in accordance with CalOptima policy, members are encouraged to self-select their preferred network. Further details on the joint special meeting are addressed in a separately agendized Advisory Committee Update.

Fiscal Impact

Should the Board change the member auto-assignment limits for CCN, Management expects the change to be budget neutral to CalOptima.

Medical Expenses

In the event the Board changes the CCN member auto-assignment limits, there is no anticipated change to total medical expenses due to variances in cost or utilization. Staff does not anticipate an increase in medical expenses due to cost as health network capitation rates are based on CalOptima's fee-for-service (FFS) provider rates and payment methodologies. The methodologies are equivalent regarding rates and assumptions. Likewise, staff does not anticipate an increase in medical expenses due to utilization as the actual historical utilization rates used in developing health network capitation rates and actual FFS utilization rates are not significantly different for similar populations. There is a large overlap (82%) between health network and CCN primary care providers, and staff assumes provider practice patterns will largely be the same whether the member is with CCN or a contracted health network provider. Also, the overall impact of the potential shift in members due to this potential policy change appears minimal and is not expected to have any measurable change in total medical expenses.

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Removed from Agenda – 11/1/2018

Administrative Expenses

In addition, the potential change to the CCN member auto-assignment limit would not materially impact overall budgeted administrative expenses. The CalOptima Fiscal Year 2018-19 Operating Budget included a consolidated administrative loss ratio (ALR) of 4.4% and a Medi-Cal ALR of 4.1%. The current CCN enrollment is approximately 75,000 members. Based on current enrollment projections, the removal of the 10% CCN auto-assignment limit would direct approximately 3,600 more auto-assigned members to CCN over a one-year period. With member choice and attrition, this number is expected to result in a net increase in CCN enrollment of roughly 1,800 on an annual basis, or by an average of roughly 150 net new members per month. As such, staff anticipates the overall impact on administrative expenses would be quite minimal and would not be expected to have any measurable impact on the ALR.

Rationale for Recommendation

The removal of the auto-assignment membership limits for CCN would potentially shift 7.8% of the average auto-assigned members to CCN providers, while 92.2% of the auto-assigned members would continue to be assigned to the other health network providers.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated September 6, 2018, Consider Changes to the Member Auto-Assignment Limits for the CalOptima Community Network
    a. Board Action dated November 5, 2009, Approve Modifications to CalOptima Direct.
    b. Board Action dated March 6, 2014, Authorize the Chief Executive Officer (CEO) to Modify CalOptima Policies as Necessary to Establish a CalOptima Community Network within CalOptima Direct.
2. CalOptima Policy EE.1106: Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment.

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

On November 5, 2009, the CalOptima Board of Directors authorized staff to organize a contracted CalOptima Direct Network. This action authorized staff to establish contracts between CalOptima directly with community providers for the delivery of health care services to CalOptima members enrolled in CalOptima Direct.

At its February 6, 2014 meeting, the Board authorized expansion of the Direct Network to include CCN, which would allow participation of a broader range of providers and to supplement the existing delivery system and expand member choice through CCN. CCN expansion was based on the following attributes:

1. Accept any willing and qualified provider;
2. Allow enrollment of any members eligible for health network enrollment;
3. Stop auto-enrollment, excluding assign-back and family link, to CCN when total enrollment reached 10% of CalOptima's overall membership; and
4. Directly contract with independent and group physicians.

At the same meeting, staff reported that CalOptima had and would continue to actively seek stakeholder feedback on the development of CCN. Some of the feedback received from existing health networks was the concern that CCN would compete with the existing networks, that it could create an incentive for physicians to no longer participate with existing networks, and that it might provide an unfair financial advantage for CalOptima, including as it related to funding and provider reimbursements levels. Other providers, including individual physicians, the Member Advisory Committee, and the Orange County Medical Association were supportive of the proposal and provided positive feedback. CCN has now been in place for several years. The CCN provider network currently includes over 3,000 contracted primary care physicians and specialists in Orange County, with nearly 75,000 assigned members. The 10% auto-assignment was closed effective April 2017, and no new members have been auto-assigned to CCN since that time. However, enrollment in CCN has continued to grow due to member selection. In terms of quality scores, CCN ranks 9th in the group of 13 health networks. Kaiser Foundation Health Plan is not included in the auto-assignment process.

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At its August 2, 2018 meeting, the Board directed staff to provide additional information regarding CCN and include an agenda item that would allow the Board to consider revisions to/removal of the 10% CCN auto-assignment cap. In the event that the Board opts to remove the 10% auto-assignment limit, as proposed, there would be no limit on CCN auto-assignment and enrollment; based on Board policy, the other contracted health networks are individually limited to a maximum of one-third of all CalOptima Members eligible for enrollment.

Fiscal Impact

Should the Board change the member auto-assignment limits for CCN, Management expects the change to be budget neutral to CalOptima.

Medical Expenses

In the event the Board changes the CCN member auto-assignment limits, there is no anticipated change to total medical expenses due to variances in cost or utilization. Staff does not anticipate an increase in medical expenses due to cost as health network capitation rates are based on CalOptima's fee-for-service (FFS) provider rates and payment methodologies. The methodologies are equivalent regarding rates and assumptions. Likewise, staff does not anticipate an increase in medical expenses due to utilization as the actual historical utilization rates used in developing health network capitation rates and actual FFS utilization rates are not significantly different for similar populations. There is a large overlap (82%) between health network and CCN primary care providers, and staff assumes provider practice patterns will largely be the same whether the member is with CCN or a contracted health network provider. Also, the overall impact of the potential shift in members due to this potential policy change appears minimal and is not expected to have any measurable change in total medical expenses.

Administrative Expenses

In addition, the potential change to the CCN member auto-assignment limit will not materially impact overall budgeted expenses. The CalOptima Fiscal Year 2018-19 Operating Budget included a consolidated administrative loss ratio (ALR) of 4.4% and a Medi-Cal ALR of 4.1%. The current CCN enrollment is approximately 75,000 members. Based on current enrollment projections, the removal of the 10% CCN auto-assignment limit would direct approximately 3,600 more auto-assigned members to CCN over a one-year period. With member choice and attrition, this number is expected to result in a net increase in CCN enrollment of roughly 1,800 on an annual basis, or by an average of roughly 150 net new members per month. As such, staff anticipates the overall impact on administrative expenses is quite minimal and is not expected to have any measurable impact on the ALR.

Rationale for Recommendation

The removal of the auto-assignment membership limits for CCN would potentially shift 7.8% of the average auto-assigned members to CCN providers, while 92.2% of the auto-assigned members would continue to be assigned to the other health network providers.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Presentation: Auto-Assignment - Summary
2. Board Action dated November 5, 2009, Approve Modifications to CalOptima Direct.
3. Board Action dated March 6, 2014, Authorize the Chief Executive Officer (CEO) to Modify CalOptima Policies as Necessary to Establish a CalOptima Community Network within CalOptima Direct.
4. EE.1106, Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment.

/s/ Michael Schrader — *8/29/2018*

Authorized Signature — **Date**

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Auto-Assignment – Summary

Board of Directors Meeting
September 6, 2018

Greg Hamblin, Chief Financial Officer

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Overview

- Auto-Assignment Policy
  - Overview of Policy
  - Performance Criteria
  - Performance Based Ranking
  - Auto-Assignment Retention Rates
- Other Quality Metrics
- Medi-Cal Enrollment by Network
- Financial Information/Considerations
- Current Policy Impact
- Policy Change Impact
- Recommended Action

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Auto-Assignment Policy

- The CalOptima Auto-Assignment Policy was structured to ensure the following:
  1. Members have access to health care services in geographic proximity to his or her residence.
  2. Community Health Center Safety Net provider participation in the CalOptima program.
     - Community Clinics
     - FQHCs
  3. Member assignment to Health Network or CCN based on performance criteria.
     - Auto-Assignment Limitation
       - Health Network maximum enrollment not to exceed 33.33% of total health network eligible members
       - CCN maximum enrollment not to exceed 10.00% of total health network eligible members
       - Auto-assignment is turned off once the maximum enrollment is reached

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Auto-Assignment Policy (cont.)

- On average ~7,000 new/returning members are auto-assigned each month
  - Assignment is based on geographic zip code locations and performance based criteria
  - Members can request to change their Health Network or CCN affiliation once per month

- Of the ~7,000 members being auto-assigned:
  - 45% or ~3,150 are auto-assigned to the Clinics/ FQHCs
    - Each Clinic/ FQHC can selected a Health Network affiliation or CCN affiliation in order to receive its allocation of auto-assigned members
    - Currently, all Clinics/ FQHCs are affiliated with the Health Networks for auto-assignment

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Auto-Assignment Policy (cont.)

- 55% or ~3,850 are auto-assigned to a Health Network or CCN
  - Currently, the Health Networks receive all auto-assignment as CCN auto-assignment is turned off based on the maximum enrollment limitation set by policy
  - Auto-assignment is based on a Health Network's or CCN's, performance-based criteria and resulting ranking
  - Performance Criteria
    - Specific performance indicators have been established
    - Each performance indicator is assigned a weight % and points
    - Relative ranking is based on the sum of weighted scores for all indicators
    - The ranking, in numerical sequence, is used as the processing order for auto-assignment
    - Results take effect the following year for a one year period

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Performance Criteria

Category	Indicator	Possible Points	Weight
Quality of Clinical Service	Well Child Visits: 3rd, 4th, 5th, 6th Years	0, 2, 5, 10	10%
	Adolescent Well-Care Visits	0, 2, 5, 10	10%
	HbA1c Testing/ Well Child Visit – 15 months	0, 2, 5, 10	10%
	Postpartum Care/ Childhood Immunization Combo 2	0, 2, 5, 10	10%
	Breast Cancer Screening/ Child Immunization MMR	0, 2, 5, 10	10%
	LDL Screening/ Appropriate Treatment Children URI	0, 2, 5, 10	10%
Administrative Excellence	Child Member Satisfaction Survey	0, 4, 10, 20	20%
	Encounters	0, 2, 5, 10	10%
	Auto-Assignment Retention Rate	0, 2, 5, 10	10%
	Total		100%

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Performance Based Ranking

Current Ranking	Medi-Cal	
	Weighting %	Relative Ranking
Health Network A	13.4%	1
Health Network B	11.1%	2
Health Network C	10.8%	3
Health Network D	9.6%	4
Health Network E	9.5%	5
Health Network F	9.1%	6
Health Network G	8.1%	7
Health Network H	7.5%	8
CCN	**6.8%**	**9**
Health Network I	5.4%	10
Health Network J	4.8%	11
Health Network K	2.9%	12
Health Network L	1.0%	13

As of January 1, 2018
Note: Kaiser is excluded from auto-assignment

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Auto-Assignment Retention Rates

- Data Source: Auto-assignments from July 2016 – March 2017
  - CCN auto-assignment was closed effective April 2017
- Measures members initially auto-assigned and their retention rate on a quarterly basis; up to a maximum of 8 quarters (2 years)
  - Measured through June 2018
- Finding: On average, CCN retention rate was 8% to 9% higher than the Health Network rate for each period

Period	Health Network	CCN	Difference
One quarter	74%	82%	8%
Two quarters	60%	69%	9%
Three quarters	52%	61%	9%
Four quarters	42%	53%	11%
Five quarters	36%	45%	9%
Six quarters	33%	41%	8%
Seven quarters	31%	40%	9%
Eight quarters	25%	33%	8%

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Medi-Cal Enrollment by Network (July 2018)

Health Network	Model	Enrollment	% Total
CHOC Health Alliance	PHC	146,549	22.5%
Monarch Family Healthcare	HMO	81,235	12.4%
CCN – CalOptima (Auto-assignment turned off)	**FFS**	**75,618**	**11.6%**
Arta Western	SRG	65,592	10.1%
Alta Med Health Services	SRG	46,335	7.1%
Family Choice Health Network	SRG	46,227	7.1%
Kaiser (No Auto-assignment by choice)	HMO	45,659	7.0%
Prospect Medical Group	HMO	33,989	5.2%
United Care Medical Network	SRG	32,334	5.0%
Noble	SRG	24,798	3.8%
Talbert Medical Group	SRG	23,889	3.7%
AMVI Care Health Network	PHC	22,386	3.4%
Heritage – Regal Medical Group	HMO	5,863	0.9%
OC Advantage	PHC	2,126	0.3%
Total Health Network Enrollment		**652,600**	**100.0%**
CalOptima Direct (No Auto-assignment)	FFS	**104,533**	
Total Medi-Cal Enrollment		**757,133**	

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Financial Information/Considerations

- 2 different Payment Models
  1. Capitation
     - PMPM is paid to a Health Network for each enrolled member
       - Capitation PMPM rates are based on CalOptima's Fee-For-Service (FFS) payment policies, methodologies and fee schedules using actual, historical incurred utilization rates
       - HMO/PHC – Capitation paid for certain Professional & Hospital services (some carve outs and re-insurance paid on FFS basis)
       - SRG – Capitation paid for certain Professional services (some carve outs and re-insurance paid on FFS basis)
  2. Fee-For-Service (FFS)
     - Provider is paid a fee for each particular service performed
       - FFS payment rates are based on CalOptima's payment policies, methodologies and fee schedules
       - CCN – Payments made on FFS basis

  ➢ Capitation rates are based on the same payment policies, methodologies and rates experienced under FFS

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Financial Information/Considerations

3. Administrative Expenses

- Capitation
  - CalOptima includes an Administrative and Medical Management load as part of the capitation rate paid to the health networks
  - The Administrative load rate is developed based on CalOptima FFS administrative and medical management costs
  - Delegated health networks only perform some of the administrative functions that CalOptima performs
  - The administrative and medical management costs that CalOptima includes as part of the capitated rates are equivalent to the incurred administrative and medical management costs experienced under FFS

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Current Policy Impact

- Under the current policy, auto-assignment to CCN is turned off when the total number of CCN members exceeds 10% of Eligible Network Enrollment
  - CCN auto-assignment was closed effective April 2017
    - Limitation is currently still in place with 0% auto-assignment to CCN
  - CCN Current enrollment is 75,618
    - 652,600 Total members x 10% = 65,260 limitation threshold

- Currently, all auto-assignment (~7,000 per month) is through the Health Networks
  - ~3,150 or 45% to Clinic/ FQHC: Selected Health Network affiliation
  - ~3,850 or 55% to Health Networks

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Policy Change Impact

- Removing the 10% Auto-assignment limitation from CCN
  - Annualized impact based on current data:
    - CCN would receive ~3,600 or 7.8% of the available members through Auto-Assignment
    - Health Networks would receive ~42,600 or 92.2% of the available members through Auto-Assignment
  - Auto-assignment member loss will significantly mitigate these numbers
    - Retention rates:
      - At the end of 4 quarters: 42% Health Network and 51% CCN
      - At the end of 8 quarters: 25% Health Network and 33% CCN
    - Member loss from auto-assignment could be due to:
      - Member choice: selecting another Health Network or CCN
      - Loss of Medi-Cal coverage
  - There would be no significant financial impact to CalOptima due to this policy change at this level of membership and historical retention rates

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Recommended Action

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Approve Modifications to CalOptima Direct

Contact
Javier Sanchez, Executive Director of State Programs, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer to organize a CalOptima Direct (COD) network to improve the quality and coordination of health care services delivered to Medi-Cal members enrolled in COD.

Background
CalOptima currently provides services to approximately 336,000 members in the Medi-Cal program. There are four components of the delivery system:

1. Health Plan services - Cost: $404 million Members: 344,982
   CalOptima pays directly for long term care room and board, pharmaceuticals, pediatric preventive services and vision care for all CalOptima Medi-Cal members

2. CalOptima Direct - Cost: $208 million Members: 103,591
   CalOptima pays fee for service expenses for medically and administratively complex members.

3. Shared Risk Groups - Cost: $172 million Members: 105,007
   CalOptima pays for hospital associated expenses and Medical Groups are capitated and subsequently pay for professional expenses.

4. Delegated Health Networks - Cost: $142 million Members: 136,384
   2 HMOs, 3 Medical Groups and 2 Hospitals are capitated and subsequently pay for professional and hospital expenses

   (Note: Cost data is based on FY 2008-09 financial statements and enrollment figures are for the month of September 2009.)

CalOptima Direct is CalOptima's fee-for-service (FFS) program for certain Medi-Cal members. COD enrollment averages approximately 100,000 members at any given time. Approximately 68,000 COD members are dual eligibles for whom Medicare is the primary payer of most expenses. The remaining populations served through COD include members who are in the process of transitioning to contracted health networks, members with a share of cost, foster children, members with Medi-Cal only Long Term Care (LTC) aid codes and members with qualified medical conditions or who have complex needs. Members with qualified medical conditions include members diagnosed with hemophilia, end stage renal

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disease (ESRD), members enrolled in the breast and cervical cancer treatment program (BCCTP), and members awaiting organ transplants. COD also serves members who were transitioned to COD under special circumstances approved by the CalOptima Board such as the Seniors and Persons with Disabilities Pilot (SPDP), and members with specific continuity of care needs who were transitioned to COD by Chief Medical Officer (CMO) approval according to CalOptima policy.

To receive reimbursement for services rendered to COD members, providers currently register with CalOptima. If a provider is contracted with COD, the provider must be credentialed by CalOptima, similar to providers who are currently contracted through CalOptima's health networks. However, in contrast to the CalOptima members assigned to the health networks and shared risk groups, COD members are free to use any willing provider registered with CalOptima. This model makes it difficult to coordinate care since members either do not have a primary care medical home or if they access primary care providers, CalOptima has no formal contractual relationship with primary care providers.

CalOptima Direct began the process of developing a contracted network in 2006, when it began contracting with hospitals. CalOptima staff received authority in June 2007 to directly contract with physicians and ancillary providers who provide services to COD members. To date, CalOptima has contracted with approximately 300 specialists and various ancillary providers and hospitals. Some of these specialists are hospitalist physicians who collaborate with CalOptima's Utilization Management staff to manage inpatient services. However, because the providers of primary care services do not hold contracts with CalOptima, they cannot be held to the same requirements that CalOptima is held to under its contract with the Department of Health Care Services (DHCS), and they are not bound to the policies and procedures approved by CalOptima. Accordingly, in order to assure compliance with approved policies and procedures and quality of care standards, and in order to assure a comprehensive model of care for COD members, CalOptima staff will contract with certain primary care physicians including those who already provide services to COD members as registered CalOptima providers.

Discussion

COD Membership

The current COD membership shall remain the same. At this point, the COD FFS program is not available for member choice, except in certain circumstances outlined in CalOptima policy.

CalOptima has determined that the following categories of members will best be served in the COD FFS program: members residing outside of Orange County; transitional members waiting to be assigned to a delegated health network; dual eligible members enrolled in One Care; members with Share of Cost (SOC); and dual eligible members not enrolled in One Care.

Members in the foster child category will continue to have the option of selecting one of CalOptima's contracted health networks or to remain in COD according to current policy. If

members in the Foster Child category choose COD, they will receive care in the COD managed network.

Members that formerly participated in the Seniors and Persons with Disabilities Pilot (SPDP) and members transitioned to COD by CMO Exception for continuity of care purposes following the termination of the St. Joseph Heritage Medical Group from Noble, will receive care in the COD Managed Network and will have the option of selecting a health network. However, unlike Foster Children, they will not have the option of choosing to return to COD (after selecting a health network) unless their status or condition changes to make them eligible in the future to be transitioned to COD based on qualifying conditions or benefits.

The following categories of COD members will receive care under the COD Managed Network: members with Medi-Cal only long term care (LTC) Aid Codes; members with continuous Medi-Cal share-of-cost (SOC) benefits; members with qualifying conditions such as those awaiting an organ transplant, diagnosed with ESRD, diagnosed with Hemophilia, those eligible for the breast and cervical cancer program (BCCTP), and institutionalized members who reside at the Fairview facility.

COD Providers
As stated above, the providers presently providing services to COD members must register with CalOptima. The process of registration simply allows CalOptima to process the provider's claim(s).

CalOptima staff believes that contracting with primary care physicians will lead to the following enhancements in the COD provider network:

- State and Federal Regulation and CalOptima Policies and Procedures – The process of contracting with a COD managed network will allow CalOptima to hold all contracted physicians to the same requirements and obligations required under its contract with DHCS. These requirements include credentialing standards, the right to access records, peer review, and corrective action plans. These requirements are similar to what CalOptima requires of its shared risk groups and health networks.
- Contracting and Coordination of Care by Primary Care Physicians (PCP) – CalOptima's 2009 contract with DHCS requires written contracts between CalOptima and each provider of health services which regularly furnishes services to members. CalOptima staff will identify physicians registered with COD as Pediatricians, Family Practitioners, General Practitioners, Obstetrician/Gynecologists and Internal Medicine (collectively defined as PCPs) that already serve COD members and offer them contracts. Contracts shall not be executed with any such provider until completion of CalOptima's credentialing standards.
- Recruitment of PCP Network – The COD provider network will include only contracted providers who meet contracting requirements as described above. CalOptima will only offer PCP contracts to physicians registered as Pediatricians, Family Practitioners, General Practitioners, Obstetrician/Gynecologists and Internal Medicine physicians who have provided outpatient services to five (5) or more unique CalOptima Medi-Cal Members from June 2007 to September 2009. In addition, CalOptima may offer

contracts to other primary care providers as necessary to ensure that COD members have adequate access to primary care services according CalOptima's contract with the DHCS.

- PCP Payment – Contracted PCPs in the COD managed network will be paid on a fee-for-service (FFS) basis at 123% of the COD fee schedule which is based on the Medi-Cal fee schedule. Registered non-contracted physicians will be reimbursed FFS at 100% of the COD fee schedule. For contracted PCPs, this reimbursement methodology will begin on the effective date of the contract. For non-contracted physicians, this methodology will be effective on April 1, 2010 in order to allow registered physicians an opportunity to contract with CalOptima. Consequently, those providers who meet the quality standards as determined by CalOptima and follow the policy and procedures of the COD managed network will be rewarded for their efforts in a manner which is similar to the way CalOptima provides incentives to health network providers. In the future, CalOptima staff may request authority to develop alternative PCP payment methodologies to compensate physicians for providing enhanced primary care services COD members.
- Coordination of Care in the COD Managed Network – The current COD FFS program as described in the background section will continue to exist in COD in order to maintain a vehicle for covering services provided to COD sub-populations that cannot be served in a coordinated model of care. The COD managed network will operate in the same manner as CalOptima's contracted health networks with respect to assignment of a primary care provider to members and function according to managed care principles. CalOptima has categorized COD members according to benefit structure and medical diagnosis, and has identified a model of care to best serve the health care needs of the members.
- PCP Assignment – Assignment of a primary care medical home, or PCP, is a fundamental aspect of a coordinated care model of care. COD members who receive care in the COD managed network will be assigned to a PCP. Members will select a PCP of their choice according to DHCS requirements and CalOptima policy. CalOptima will make several attempts during a six-month period to allow each member served in the COD managed network to select a PCP of their choice. Members who do not select a PCP during the six-month phase in period ending June 30, 2010 will be assigned to a PCP based on the following criteria:
    - The first attempt will be to identify and assign members to a contracted PCP that the member accessed during in the last year (based on claims data).
    - If a prior primary care provider cannot be identified, members will be assigned to a contracted PCP who is located near the member's address .
    - Members will be allowed to change PCPs once per month in the same manner as members assigned to CalOptima's health networks, and according to CalOptima's policy.

  Members that remain in COD FFS, as described above, will not be assigned to a PCP.

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Quality and Fiscal Impact

As the COD managed network development process moves forward, the impact on the quality of care should be significant. Additionally, the financial impact should reflect savings in total healthcare costs. A coordinated utilization management program and early intervention for hospitalized Medi-Cal patients should allow CalOptima to improve quality of care, while decreasing healthcare costs for COD members.

CalOptima staff will track the financial performance of the COD provider network through monthly financial statements which will track performance against a fiscal year budget. Revenue for the COD managed network budget will be based on CalOptima's capitation rates and will be risk adjusted in the same manner as health network capitation is adjusted. Retroactive expenses will be accounted for in COD FFS expenses and shall not be considered COD managed network expenses.

Rationale for Recommendation

Staff recommends that CalOptima complete the development of a contracted primary care network and a coordinated model of care within COD. The intent of this proposed change is to ensure that quality healthcare, provided cost effectively, will be delivered in the most appropriate manner to the COD membership.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachment

CalOptima Direct Model of Care Matrix

/s/ Richard Chambers — *10/29/2009*

Authorized Signature — **Date**

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Attachment to:
November 5, 2009, VI. C.

CalOptima Direct Model of Care Matrix

Membership Category	Average Monthly Enrollment	Source of Enrollment	COD FFS	COD Managed Network Optional – Choice of HN or COD	COD Managed Network Optional – One Way out of COD	COD Managed Network
Out of Area as defined by the State	140	Newly Eligible	✓			
HN Transitional	9,500	Newly Eligible	✓			
Medi-Medi *IN* OneCare	9,300	Newly Eligible	✓			
Share of Cost	450	Newly Eligible	✓			
Medi-Medi *NOT IN* OneCare	59,500	Newly Eligible	✓			
Foster Care	3,860	Newly Eligible		✓		
Members of the former Seniors and Persons with Disability Pilot (SPDP)	1,970	Monarch UCI PHC			✓	
CMO Exception: • **Members living with HIV/AIDS** • **Continuity of Care: St. Joseph Heritage Termination**	500	Transitioned from Health Networks			✓	
Medi-Cal Only LTC Aid Codes	4,500	Newly Eligible				✓
Qualified Medical Conditions: • **Organ Transplant list** • **End Stage Renal Disease (ESRD)** • **Hemophilia** • **Breast and Cervical Cancer Treatment BCCTP Program**	1,500	Newly Eligible Transitioned from Health Networks				✓
Fairview Residents	100	Newly Eligible				✓

All Members in the COD Managed Network will be assigned a primary care physician

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. J. Authorize the Chief Executive Officer (CEO) to Modify CalOptima Policies as Necessary to Establish a CalOptima Community Network within CalOptima Direct

Contacts

Javier Sanchez, Chief Network Officer, (714) 246-8400
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the CEO to take the following actions necessary to establish a community network within CalOptima Direct for all lines of business:

1. Update Member enrollment and eligibility policies for Medi-Cal, OneCare and Cal MediConnect including CalOptima Direct Policy DD.2006; and
2. Allow budget flexibility among expense categories during Fiscal Year (FY) 2013-14 as appropriate based on new CalOptima Direct membership as a result of policy changes.

Background

On November 5, 2009, the CalOptima Board of Directors (Board) authorized staff to organize a contracted CalOptima Direct network to improve the quality and coordination of health care services delivered to Medi-Cal members enrolled in CalOptima Direct. This action authorized staff to establish contracts between CalOptima Direct and providers for the delivery of health care services to CalOptima members. Prior to this Board action, CalOptima Direct was a loosely managed fee-for-service delivery model with limited provider contracts.

In February 2013, the Board directed staff to explore options for expanding CalOptima's delivery system. Based on strong collaboration with community and provider stakeholders, CalOptima management subsequently issued a Request for Proposals (RFP) to add new networks and sought stakeholder input regarding possible options.

CalOptima completed a successful RFP process, identifying 118 potential new primary care providers and 975 new specialists to be added to the provider network. These providers would be included in the network after successfully passing a readiness review. In addition, CalOptima continued preparations for participation in the Cal MediConnect program. During this process, it was determined that CalOptima must place an even greater emphasis on the patient/provider relationship, and seek to further expand the provider network in order to minimize the opt-out rate for Cal MediConnect and maximize provider participation.

At its December 2013, the Board authorized the CEO to further explore and evaluate the possible expansion of the provider delivery system through the creation of a direct CalOptima Community Network. Specifically, CalOptima staff understood the direction of the Board to require that CalOptima:

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- Seek input from existing health networks and other stakeholders;
- Solicit letters of interest from providers;
- Define network criteria and implementation requirements;
- Evaluate potential costs and areas of risk including:
  - Impact to existing networks and delivery system and provider participation requirements for individual lines of business;
  - Changes in member care resulting from the inclusion of providers not selected by current networks and any related quality or credentialing issues;
  - Financial ramifications of potential risk shifting (i.e., increases to risk resulting from adverse selection) based on provider participation in both the network and direct models with the same membership;
  - Additional staffing and other potential administrative costs associated with managing a new network; and
- Return to Board in February 2014 with findings and recommendations.

Discussion

Consistent with CalOptima's mission to focus on expanding member choice and ensuring continuity of care, staff proposes that the Board authorize the development of a new Community Network within CalOptima Direct that will allow providers to contract with CalOptima directly to provide services to members in all CalOptima programs, including those currently eligible for Health Network assignment. While the CalOptima Community Network will provide value to all CalOptima members, it is particularly important for expanded provider options for members in Cal MediConnect once participation in the program is approved by federal and state regulators.

While it will be part of CalOptima Direct, the proposed CalOptima Direct Community Network will be separate and distinct from the CalOptima Care Network which delivers services to specific CalOptima Medi-Cal populations. The CalOptima Direct Community Network would be built on four (4) primary constructs:

1. Accept any willing and qualified provider;
2. Allow enrollment of any members eligible for health network enrollment;
3. Stop auto enrollment, excluding assign-back and family link, to the Community Network when total enrollment reaches 10% of CalOptima's overall membership;
4. Directly contract with independent and group physicians (i.e., no delegation of services).

As currently envisioned, the Community Network would be part of CalOptima Direct and have responsibility for all administrative services, managed care operations, and delivery of services to members not delegated to contracted Health Networks. CalOptima's leadership team brings many years of experience in managing a direct network and implementing these operational functions.

To ensure a level playing field with existing contracted health networks, physicians contracting with CalOptima Direct's Community Network would be required to: (i) participate in all CalOptima programs, and (ii) be qualified to provide services to all membership categories as appropriate. Physicians and other providers would have the option of participating in multiple networks.

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CalOptima originally expressed interest in developing a CalOptima Direct Community Network consisting of only those physicians who were not contracted with an existing network. However, consistent with current practice of permitting physicians to participate in multiple networks, the proposal has been amended to expand participation to all physicians.

Based on the direction provided by the Board in December 2013, staff has taken a number of exploratory steps, including soliciting input from a range of stakeholders and further defining the network criteria and implementation requirements.

Stakeholder Feedback
CalOptima has and will continue to actively seek stakeholder feedback on the development of the CalOptima Direct Community Network. The current request was developed and includes stakeholder feedback that was sought and received between the February 2013 and December 2013 BOD meetings. Since the December 2013 Board of Directors meeting, staff planned and conducted the following stakeholder events:

Meeting	Date
Health Network CEO Forum	12/12/13
CalOptima Member Advisory Committee (MAC)	1/16/14
CalOptima Provider Advisory Committee (PAC)	1/16/14
Health Network Forum	1/22/14
Financial Advisory Committee (FAC)	2/18/14
Monthly Cal MediConnect Stakeholder Forums	November, January and February

CalOptima received a range of feedback from stakeholders at these meetings. Individual physicians, the Member Advisory Committee, and the Orange County Medical Association were supportive of the proposal and provided positive feedback. The strongest concerns were expressed by existing health networks. Feedback included concerns that establishing the CalOptima Direct Community Network would:

- Create competition between the CalOptima Direct Community Network and existing Networks;
- Create an incentive for physicians to no longer participate with existing Networks; and
- Create an unfair financial advantage for CalOptima, including funding and provider reimbursements levels.

There were three (3) major risk categories identified during the stakeholder process. The categories and associated mitigation is outlined below:

1. Member Experience and Changes in Member Care
   CalOptima's first priority is ensuring access to high quality care for members. The creation of a CalOptima Direct Community Network will improve member access to care in several key ways:
   - Provide CalOptima the flexibility to create a broader provider network for members to choose from;
   - Create an avenue for physicians who do not currently contract or fully participate with

health networks to serve CalOptima members; and
- Enable CalOptima to preserve existing member-provider relationships for members transitioning to CalOptima and for existing Dual Eligible Medi-Cal members newly receiving their Medicare benefits from CalOptima.

CalOptima is projected to experience a rapid increase in enrollment. CalOptima's expected growth will primarily come from Medi-Cal Expansion and Cal MediConnect. Ensuring flexibility in contracting and service delivery is critical to meeting the needs of new populations.

2. Provider Participation and Impact to Existing Networks
One of the primary goals for the CalOptima Direct Community Network is to allow independent physicians and small provider groups to contract with CalOptima to provide services to members in all CalOptima programs. Physicians participating in the CalOptima Direct Community Network will be required to meet the same strict quality standards that are required of all Medi-Cal participating providers. CalOptima has solicited and received letters of intent (LOI) from over 400 primary care and specialty physicians and nine (9) Community Clinics to participate in the CalOptima Community Network. Of the total number of physicians, about 8% are new to the CalOptima delivery system.

The creation of the CalOptima Community Network will allow the participation of a broader range of providers. However, the impact of a new CalOptima administered network on existing health networks must carefully be evaluated. Staff has actively worked with the health networks to identify, understand, and determine ways to address their concerns. As a result, the CalOptima Direct Community Network will supplement the existing delivery system and the proposed design will include several safeguards to ensure that health networks continue to operate on a level playing field:
- The CalOptima Direct Community Network would be required to meet the same contractual requirements as existing networks;
- The CalOptima Direct Community Network would be treated like all other networks in the member assignment process;
- Physicians and other providers would have the option of participating in multiple networks; and
- CalOptima will track the financial performance of the Community Network separate from the CalOptima Care Network.

3. Financial Risk Shifting and Administrative Costs
In order for the CalOptima Direct Community Network to be successful, CalOptima must control for risk shifting, monitor member panel acuity between networks, and control for administrative efficiency. If approved, CalOptima staff will develop policies to strengthen continuity of care requirements and create dis-incentives to prevent risk shifting by delegated health networks such as requiring that delegated health networks be financially responsible for the cost of services provided to members that move from a health network to the CalOptima Direct Community Network for a period of time.

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The current risk adjusted revenue per member per month (PMPM) will be applied to the CalOptima Direct Community Network, consistent with how current health networks are reimbursed. By monitoring this closely and adjusting for member acuity, CalOptima will have the appropriate controls in place to prevent risk shifting between networks.

Administrative costs will be comparable to or better than the current administrative ratio, including the health networks. This reflects that all functions will be performed by CalOptima and have little to no delegation, with credentialing being the exception. Functions performed by CalOptima will include, but are not limited to case management, claims processing, customer service, and utilization management.

As noted above, the CalOptima Direct Community Network would be required to meet the same contractual requirements as existing health networks. In order to serve CalOptima members, the CalOptima Direct Community Network would be required to pass a comprehensive readiness review. Staff will also regularly evaluate the efficiencies and effectiveness of the CalOptima Direct Community Network, and will provide regular communications to the Board and our member and provider communities. In addition, staff will return to the Board for consideration of further related policy considerations, as appropriate.

Fiscal Impact
The recommended action is expected to be budget neutral to CalOptima. Staff is not requesting a budget augmentation to the FY 2013-14 Operating Budget; however, staff requests budget flexibility among expense categories as appropriate based on membership in the CalOptima Direct Community Network.

Rationale for Recommendation
The establishment of a direct CalOptima Community Network provides a significant opportunity for CalOptima to increase member access to care, broaden the network of physicians in Orange County and, increase CalOptima's direct contact with members. The CalOptima Direct Community Network will enable CalOptima to expand capacity and expertise, and generate greater administrative efficiencies.

Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *2/28/2014*
Authorized Signature — **Date**

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Policy #:	EE.1106
Title:	**Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment**
Department:	Network Management
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	03/01/96
Last Review Date:	08/01/17
Last Revised Date:	08/01/17

I. PURPOSE

This policy establishes minimum and maximum Member enrollment for a Health Network, Primary Hospital, Primary Physician Group, and CalOptima Community Network (CCN).

II. POLICY

A. Minimum enrollment

1. The minimum enrollment requirement shall apply to a Health Network and CCN thirty-six (36) months after the initial Member enrollment date.

2. After the initial thirty-six (36) months of Member enrollment, a Health Network shall maintain a Member enrollment of at least five-thousand (5,000) Members for the remainder of the term of the Contract for Health Care Services.

3. If a Health Network fails to maintain an average Member enrollment over three (3) consecutive months of at least five-thousand (5,000) Members, CalOptima may terminate the Contract for Health Care Services in accordance with the terms of that contract.

B. Maximum enrollment

1. Except as otherwise provided in Section II.B.3. of this policy:

   a. Combined Member enrollment in a Primary Hospital or Primary Physician Group shall not exceed one-third (1/3) of all Members eligible for Health Network enrollment.

   b. Member enrollment in a Health Network shall not exceed one third (1/3) of all Members eligible for Health Network enrollment.

   c. Combined Member enrollment in CCN shall not exceed ten percent (10%) of all Members eligible for Health Network enrollment.

2. If a Health Network, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, such Health Network, Primary Hospital, or Primary Physician Group shall not be eligible to contract with CalOptima as part of an additional Health Network.

3. Subject to the provisions of this policy, CalOptima shall continue to enroll Members in a Health Network, or CCN, until the Health Network, CCN, Primary Hospital, or Primary Physician

Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months.

a. If a Health Network reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto assignment of Members to the Health Network effective the first (1st) calendar day of the immediately following month.

b. If a Primary Hospital or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto-assignment of Members to each Health Network comprised of such Primary Hospital or Primary Physician Group effective the first (1st) calendar day of the immediately following month.

c. If CCN reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto assignment of Members to CCN effective the first (1st) calendar day of the immediately following month.

d. Notwithstanding the provisions of this section, CalOptima shall continue to enroll a Member in a Health Network, or CCN, if:

i. The Member selects the Health Network or CCN in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process;

ii. The Member has Family Linked Members currently enrolled in the Health Network or CCN;

iii. The Member is re-enrolled in the Health Network, or CCN, after experiencing a lapse of Medi-Cal eligibility less than three-hundred-sixty-five (365) calendar days in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process;

iv. The Member otherwise meets criteria for enrollment into CCN, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

v. CalOptima auto assigns the Member to the Health Network or CCN based on auto assignment allocation to a Community Clinic as set forth in CalOptima Policy AA.1207a: CalOptima Auto Assignment; or

vi. CalOptima's Chief Medical Officer (CMO) or Designee determines that it is in the Member's best interest to enroll in the Health Network or CCN.

C. Health Network Enrollment Changes

1. CCN and a Health Network, and its Contracted Providers, shall not advise, urge, or otherwise encourage Members to change Health Networks as a direct result from the Member's medical history or health status.

2. CCN and a Health Network shall be responsible for all Members who either select or are otherwise auto-assigned to the Health Network and are strictly prohibited from discriminating against Members based on:

a. Diagnosis;

b. Medical or claims history;

c. Age;

d. Mental or physical disability;

e. Genetic information;

f. Source of payment;

g. Sexual orientation;

h. Marital status;

i. Creed;

j. Religion;

k. Sex/Gender identity;

l. Race;

m. Color;

n. Ancestry; and

o. National origin.

3. CalOptima shall process alleged acts of discrimination in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

D. CalOptima's Board of Directors shall have the right to selectively waive a Health Network's or CCN's minimum and maximum enrollment or limit a Health Network's or CCN's enrollment if it determines that such action is in the best interest of Members.

III. PROCEDURE

A. Minimum and Maximum Enrollment

1. CalOptima's Health Network Relations Department shall monitor a Health Network, CCN Primary Hospital, and Primary Physician Group enrollment for compliance with the minimum and maximum enrollments set forth in this policy.

2. If a Health Network fails to maintain an average enrollment over three (3) consecutive months of at least five-thousand (5,000) Members after the initial thirty-six (36) months, of the initial Member enrollment:

a. CalOptima's Health Network Relations Department shall notify the CalOptima's Compliance Committee; and

b. Upon approval from CalOptima's Compliance Committee, CalOptima's Regulatory Affairs & Compliance Department will review the Health Network's non-compliance and issue a notice in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

3. If a Health Network, CCN, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months:

   a. CalOptima's Health Network Relations Department shall notify CalOptima's Compliance Committee;

   b. Upon approval from CalOptima's Compliance Committee, CalOptima's Network Management Department shall notify the Health Network, CCN, Primary Hospital, or Primary Physician Group that such Health Network, CCN, Primary Hospital, or Primary Physician Group is not eligible to contract with CalOptima for any other Health Network;

   c. Upon approval from CalOptima's Compliance Committee, and except as provided in Section II.B.3.c. of this policy, CalOptima shall cease Member auto-assignment to the Health Network and shall make appropriate adjustments to the auto-assignment allocation as set forth in CalOptima Policy AA.1207a: CalOptima Auto Assignment; and

   d. CalOptima's Health Network Relations Department shall notify the Health Network, Primary Hospital, Primary Physician Group, or CCN of the enrollment limit.

4. If Member enrollment in a Health Network, CCN, Primary Hospital, or Primary Physician Group falls below the maximum enrollment limit for three (3) consecutive months, CalOptima shall reinstate Member auto assignment to the Health Network.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy AA.1207a: CalOptima Auto Assignment
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
E. CalOptima Policy HH.1104: Complaints of Discrimination
F. CalOptima Policy HH.2002Δ: Sanctions
G. CalOptima Policy HH.2005Δ: Corrective Action Plan

VI. REGULATORY AGENCY APPROVALS

A. 03/29/16: Department of Health Care Services
B. 01/23/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 08/04/16: Regular Meeting of the CalOptima Board of Directors
B. 03/06/14: Regular Meeting of the CalOptima Board of Directors
C. 08/30/06: Regular Meeting of the CalOptima Board of Directors
D. 05/07/02: Regular Meeting of the CalOptima Board of Directors
E. 01/05/99: Regular Meeting of the CalOptima Board of Directors
F. 03/12/96: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	03/01/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	03/07/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	01/01/2007	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	12/01/2011	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	09/01/2014	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	02/01/2016	EE.1106	Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	08/04/2016	EE.1106	Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	08/01/2017	EE.1106	Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima, its contracted Health Networks or Physician Medical Groups.
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.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A Member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Hospital	A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy and Approving Related Scope of Work

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to issue a Request for Proposal (RFP) for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system; and
2. Approve the related attached Scope of Work (SOW).

Background/Discussion

At the September 6, 2018 Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October meeting to consider issuing an RFP to conduct a market study to analyze CalOptima's provider network strategy. Staff was also directed to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Pursuant to the Board's direction, Management made presentations on the CalOptima delivery system at the MAC and PAC meetings, held separately on September 13, 2018. Both the MAC and PAC recommended holding a special joint meeting on October 11, 2018, with members of the MAC, OneCare Connect (OCC) MAC and PAC to allow for more discussion and public comments from providers and community stakeholders on this topic.

At the October 4, 2018 meeting, the Board authorized expansion of the existing actuarial service engagement with Milliman, Inc. to include additional actuarial work and the expenditure of unbudgeted funds in an amount not to exceed $35,000 from reserves. The additional actuarial activities are identified as the responsibilities of the "Existing Consultant" in Attachment 1.

On October 11, 2018, members of the MAC, OCC MAC and PAC held a special joint meeting. After further discussion and public comments from stakeholders, the committees did not support the issuance of an RFP for consulting services to analyze the provider network strategy. The main reasons given were:

- No major issues or concerns with the current delivery system – CalOptima and its existing delivery system was recently recognized as the top rated public Medi-Cal plan for the fifth consecutive year;
- Study lacks a clear purpose;
- May not be the best time to conduct a study; concerns about limited resources with new program implementation forthcoming; and

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- CalOptima already undergoes many audits and has quality matrices in place; no additional value to expending limited resources on retaining an outside consultant.

These concerns are addressed in greater detail in a separately agendized item under Advisory Committee Updates.

In response to the Board's prior directive, Staff considered the information that would be most helpful to the Board in evaluating the current delivery system and making recommendations on further refinements going forward. Staff prepared the attached document delineating the proposed research information categories. The document also makes recommendations on whether information in each particular category would be gathered and presented by Staff, by expanding the scope of current consulting services being performed by Milliman, Inc., CalOptima's currently contracted actuarial consultants, or by engaging other outside consultant(s). As indicated, the Board took action at its October 4, 2018 meeting to authorize expanding the scope of the existing Milliman contract.

Consistent with the Board's prior direction, Staff presented the same delivery system Information Items the Board received at its September 6th meeting to the MAC and PAC at their September 13, 2018 meetings. MAC and PAC members held a special joint meeting on October 11, 2018, for further discussion on these topics.

Should the Board elect to move forward with this initiative, pursuant to CalOptima Policy GA.5002: Purchasing, Staff would generate an RFP for consulting services to complete data analysis and perform a market survey. Upon completion of the contracted work, the findings would provide additional information to assist the Board in evaluating the current state of CalOptima's healthcare delivery system and setting future direction.

As proposed, an evaluation team consisting of CalOptima's Executive Director of Network Operations, CEO, Chief Operating Officer, Chief Financial Officer, and Procurement Manager, will evaluate each of the proposals received. Management would return to the Board to request authority to contract with the recommended consulting services vendor at a future Board meeting. Assuming the Board is in agreement with the categories and breakdown of Staff/consultant responsibilities as summarized in Attachment 1, the SOW for the RFP for consulting services would be limited to those items designated as the responsibilities of the "New Consultant" in the attachment.

Fiscal Impact

In the event the Board adopts the recommended actions authorizing the CEO to issue an RFP for consulting services to provide data analysis and perform a market survey and to approve the related SOW, the fiscal impact is unknown at this time. Upon completion of the RFP, Staff will return to the Board to request appropriate funding for the cost of the consulting services.

Rationale for Recommendation

In response to the Board directive, Staff has undertaken a vetting process on conducting an RFP for consulting services to obtain information to assist the Board in evaluating the current delivery system and setting direction going forward. Should the Board authorize moving forward with this initiative, following completion of an RFP process, Staff will return to the Board with further recommendations.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

/s/ Michael Schrader *10/24/2018*
Authorized Signature **Date**

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Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
1. Explore various actuarial methodologies to risk adjust revenues and medical expenses across health network types to account for differences in population acuity and expenses.		√		This will allow for a more complete comparison of various utilization metrics and Medical Loss Ratio (MLR) calculations for Medi-Cal; without risk adjusted revenues and expenses, various comparisons are not appropriate.
2. Perform network MLR comparative analysis	√			CalOptima has data providing expense side of the calculation; need Req. 1 to risk adjust the revenue. Without risk adjusted revenue, the comparison is not appropriate.
3. Establish pre-contracting criteria for additional new health networks			√	CalOptima has pre-contracting criteria in place (from last RFP). A Consultant can be engaged to develop and propose minimum requirements that must be met prior to actual contracting.
4. Develop rationale and support for minimum/maximum membership limitation			√	Related to Req. 3, a Consultant can be engaged to provide an independent analysis and supporting rationale for minimum/maximum membership requirements.
5. Review current auto assignment criteria and model, including survey of other Southern California health plans criteria/model			√	CalOptima has methodology in place. A Consultant would be engaged to survey other plans and provide independent support for an auto assignment model and process.
6. Survey and verify payment methodologies used by health networks			√	A Consultant would be engaged to survey payment methodologies used to pay downstream providers, including primary care providers, specialists and hospitals.
7. Develop network performance evaluation tool/report card			√	CalOptima has surveyed several other Southern California health plans, and has most all of the various benchmarks, scorecards and performance criteria that can be used to develop a network performance evaluation tool/report card
8. Perform survey of other Southern California health plans (particularly COHS and Local Initiative plans) to include Delegated – Direct			√	CalOptima has informally surveyed several other Southern California health plans and has a good understanding of the various network models and different

Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
model mix, payment models (i.e., capitation, FFS, other) and other obtainable comparative metrics. Include a clear statement and analysis of recommended future directions, given the progression of ideas, pilots, and other successful models of integrated, managed care delivery systems throughout the country.				payment methodologies currently in place. Additional work can be performed to provide a more complete understanding, including examples of progressive network models and/or payments systems employed in the country that CalOptima may want to consider in the design of its network delivery system.
9. Review Member Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
10. Review Provider Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
11. Develop an administrative cost allocation model to allocate costs to the networks that is based on appropriate methodologies	√		√	CalOptima has an administrative cost allocation methodology in place. It is in the process of being reviewed and modified.
12. Consider information from the CalOptima Member Health Needs Assessment that may impact the network delivery system	√		√	Consider information included in the CalOptima Member Health Needs Assessment as it may impact the network delivery system.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Actions Related to the Regulatory Requirement for Medi-Cal Provider Enrollment by the California Department of Health Care Services

Contact

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

Recommended Actions

Authorize the following actions related to the requirement that all contracted providers be enrolled in the Medi-Cal program through the Department of Health Care Services (DHCS) by January 1, 2019:

1. Authorize CalOptima to continue to contract with non-Medi-Cal enrolled providers through June 30, 2019, subject to CalOptima's receipt of proof that each such provider's application to the State to become enrolled in the Medi-Cal program was submitted to the DHCS prior to January 1, 2019; and
2. Authorize Letters of Agreement (LOA) with non-Medi-Cal enrolled specialist providers identified by the Chief Medical Officer through December 31, 2019 as required for access to services or continuity of care.

Background

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The revised regulation included requirements that providers in Managed Care Plans (MCPs) including CalOptima be subject to the same provider enrollment and screening requirements as providers who participate in Medicaid State fee-for-service programs. Provider enrollment and screening is in addition to credentialing requirements and is meant to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

On November 14, 2017, DHCS issued All Plan Letter (APL) 17-019, which specified MCP's responsibilities related to the screening and enrollment of all Medi-Cal network providers.

The contract between DHCS and CalOptima effective January 1, 2009, discontinued the requirement that providers be eligible for participation in the Medi-Cal Program. However, on October 7, 2010, the CalOptima Board of Directors approved the continuation of a policy which requires that providers furnishing services to CalOptima Medi-Cal members be enrolled with the State of California's Medi-Cal Program when an enrollment path with the State is available for the provider. In recognition that not all providers eligible to enroll with Medi-Cal would enroll, the Board also approved a policy allowing the Chief Medical Officer, or delegated providers in conjunction with the Chief Medical Officer, to make exceptions to this policy to satisfy access and continuity of care requirements in CalOptima's contract with DHCS.

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Although the new state mandated enrollment and screening requirements were effective January 1, 2018, DHCS guidance clarified that non-enrolled providers contracted with the MCPs prior to this date, have until December 31, 2018 to complete the process. Presumably, providers not enrolled by his date are to be terminated as a MCP participating provider for Medi-Cal services. Staff continues to review provider data to determine the number of non-enrolled providers and the potential impact to the members who are in their care should these providers no longer be available in the future due to their non-enrolled status.

DHCS specifies that provider screening and enrollment can be accomplished in two ways. MCPs may direct providers to the Medi-Cal enrollment division of DHCS for screening and enrollment, or MCPs may develop and implement an internal screening and enrollment process that meets the requirements of the APL. Due to the numerous additional requirements associated with the enrollment and screening process and the expertise required to fulfill these requirements, CalOptima staff believes it is more appropriate to continue to depend on the State's process to assure providers are properly vetted for Medi-Cal participation rather than to develop a duplicative process that would, in any case, lack the breadth of potentially relevant information available to the State, but not necessarily available to CalOptima.

Staff continues to conduct extensive outreach efforts to encourage non-enrolled providers to seek enrollment in the Medi-Cal program and continued participation with CalOptima. The outreach efforts have been successful, and Staff has identified the addition of over 900 previously non-enrolled providers since April 2018.

However, because the State's Medi-Cal enrollment process can take up to 180 days to complete, it is unlikely that all of the approximately 1,200 CalOptima providers not currently enrolled will complete this process by the end of the calendar year. Staff has gathered information on non-enrolled providers currently serving CalOptima Medi-Cal beneficiaries, identifying the number, specialty and potential member impact of terminating provider contracts. In the event that the existing contracts of all 1,200 currently non-enrolled CalOptima Medi-Cal providers were terminated, the results would be significant, affecting over 26,0000 Members' PCP assignments and more than 10,000 Members who access specialty care. To mitigate this potential disruption to the provider network and assure member's continued access to care, Staff is requesting Board approval of the recommended actions.

Discussion

Staff recommends that providers who are not currently enrolled with Medi-Cal but can provide proof that their Medi-Cal provider enrollment application and all required information has been submitted to the State prior to January 1, 2019, continue as contracted CalOptima participating providers until such a time as DHCS renders a decision on that provider's Medi-Cal enrollment application, potentially through June 30, 2019. As noted above, the Medi-Cal enrollment process with the state may take up to 180 days. This is a concern shared by many health plans state wide, with many opting for a similar approach of attempting to minimize member care disruption while the state works through the backlog of provider Medi-Cal enrollment applications, while also working to comply with the prescribed timelines.

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While the proposed approach of allowing additional time for the Medi-Cal enrollment process to be completed without reassigning Members from Providers with pending applications to those who have completed the DHCS Medi-Cal provider enrollment process potentially places CalOptima at risk for payment and for DHCS audit findings of CalOptima's non-compliance with the terms of the DHCS-CalOptima contract, as indicated, our understanding is that this is an approach being followed by numerous other plans to allow time for DHCS to work through the backlog of Medi-Cal provider enrollment applications.

Under the proposed approach, if any such provider is still not Medi-Cal enrolled by June 30, 2019, their contract with CalOptima will be not be extended thereafter. In addition, all non-enrolled PCPs will have their panels closed to new members until their Medi-Cal enrollment is complete. Should the provider still be in the enrollment process by June 30, 2019 (i.e., application submitted to the state on or before December 31, 2018, but state review process not having been finalized as of June 30, 2018), Staff will consider returning to the Board with further recommendations. This scenario would only be a possibility in the event that there were further delays in the state's enrollment process.

Apart from those providers who have indicated that they plan to submit their Medi-Cal enrollment applications on or before December 31, 2018, staff has identified members in care with non-enrolled providers who are required for access and may choose not to apply to enroll in Medi-Cal. The impact of terminating these providers could create barriers to access sensitive or highly specialized services and/or redirecting members to other providers may be disruptive to member care. Staff proposes to proactively pursue LOAs with these terminated providers to allow for uninterrupted access by Members for whom there is not a suitable alternative contracted provider at this time. DHCS has advised MCPs that MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis. COC requests would be processed in accordance with CalOptima's DHCS-approved policies on the topic. Staff plans to proactively identify members in care with non-enrolled providers required for access; subject to Board approval, Staff will enter into LOAs for members currently in care with these providers to enable members and providers to continue uninterrupted care as longer-term efforts are undertaken to ensure that, member care is being provided by Medi-Cal enrolled providers.

As indicated, implementation of these actions without DHCS approval could place potentially place CalOptima and other plans throughout the state at risk for any payments made to such non-Medi-Cal enrolled providers and may also result in audit findings from the State, the consequences of which may be corrective action plan(s) and/or sanctions. However, with a focus on ensuring member access to crucial healthcare services, staff recommends proceeding with the proposed approach.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget, approved by the Board on June 7, 2018, includes forecasted professional medical expenses. The recommended actions to continue contracts with certain non-Medi-Cal enrolled providers through June 30, 2019, and issue to certain specialist providers are not projected to result in a material change to the budgeted medical expenses. Therefore, the recommended actions are budgeted items with no additional fiscal impact assuming the State takes

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no actions related to payments made to non-enrolled providers and does not find CalOptima to be non-compliant and issue sanctions or take other related action(s).

Management will include revenue and expenses for the period of July 1, 2019, through December 31, 2019, related to the LOAs with certain specialist providers in future operating budgets.

Rationale for Recommendation

Continued access to providers in the process of being enrolled in Medi-Cal and services identified as crucial to avoid barriers in access to care will allow members to receive uninterrupted care notwithstanding the DHCS requirements that all providers enroll in the Medi-Cal program effective January 1, 2019.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS issued All Plan Letter (APL) 17-019
2. CalOptima Board Action dated October 7, 2010, Authorize Revisions to Credentialing and Provider Participation Requirements in CalOptima's Medi-Cal Program

/s/ Michael Schrader — **Authorized Signature**

10/24/2018 — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: November 14, 2017

ALL PLAN LETTER 17-019
SUPERSEDES ALL PLAN LETTER 16-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F,[1] dated May 6, 2016. Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 Code of Federal Regulations (CFR), Section 438.214.[2] This APL supersedes APL 16-012.[3] The screening and enrollment responsibilities are located in Part: 1 and the credentialing and recredentialing responsibilities are located in Part: 2 of this APL.

All MCP network providers must enroll in the Medi-Cal Program. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through the Department of Health Care Services (DHCS). MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018.

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC[4] to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act. The intent of Title 42 CFR, Part 455, Subparts B and E[5] was to reduce the

[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] Title 42 CFR Section 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1214
[3] APL 16-012 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-012.pdf
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] Title 42 CFR, Part 455, Subparts B and E are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

In May 2016, CMS issued rulemaking CMS-2390-F, which extended the provider screening and enrollment requirements of 42 CFR, Part 455, Subparts B and E to MCP contracted providers (Title 42 CFR, Section 438.602(b)). These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

MCPs are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal Program. Title 42 CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers[6] as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards that the Medi-Cal managed care program and MCPs must now implement.[7] Although the implementation date for Title 42 CFR Section 438.602(b) is not scheduled until July 1, 2018, Section 5005(b)(2) of the 21st Century Cures Act (Cures Act),[8] requires managed care network provider enrollment to be implemented by January 1, 2018.

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[9] Credentialing is defined as the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

[6] Exhibit E, Attachment 1 Definitions. The MCP Boilerplate contracts can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[7] State-specific Medi-Cal FFS provider enrollment requirements are contained in Title 22, CCR, Section 51000 through 51051, and Welfare & Institutions Code, Division 9, Part 3, Chapter 7 (commencing with Section 14043).
[8] 42 USC § 1396u-2 (d)(6)(A)
[9] Exhibit A, Attachment 4, Credentialing and Recredentialing.

POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal[10] to obtain a list of currently enrolled Medi-Cal FFS providers. MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through the DHCS enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP may not also participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from, the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through DHCS.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

MCP Enrollment Processes

If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[11] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and

[10] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

[11] Applications packages by provider type can be found at the following: http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types see Title 22 CCR 51000 – 51000.26 and 51051.

completeness. MCPs must ensure that all information specified in Title 22, California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments to the application package have been received. The MCP must obtain the provider's consent in order for DHCS and the MCP to share information relating to the provider's application and eligibility, including but not limited to issues related to program integrity.

MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[12] The application fee for calendar year 2017 is $560. Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. DHCS Provider Enrollment Agreement and Plan Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state (DHCS Provider Enrollment Agreement) as a condition of participating in the Medi-Cal Program pursuant to Section 1902(a)(27) of the Social Security Act and Section 14043.1 of the Welfare & Institutions Code. As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the DHCS Provider Enrollment Agreement. This provider agreement is separate and distinct from the Plan Provider Agreement (see below). MCPs must maintain the original signed DHCS Provider Enrollment Agreement for each provider and must submit a copy to DHCS, CMS, and other appropriate agencies upon request. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and place that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Plan Provider Agreement) is separate and distinct from the DHCS Provider Enrollment Agreement. Both the DHCS Provider Enrollment Agreement and the Plan Provider Agreement are required for MCP network providers. The DHCS Provider Enrollment Agreement does not expand or alter the MCP's existing rights or obligations relating to its Plan Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42, CFR, Sections 455.104, 455.105, and 455.106, and Title 22, CCR, Section 51000.35. Providers who are unincorporated sole-proprietors are not required to

[12] Application Fee information is available at: http://www.dhcs.ca.gov/provgovpart/Pages/AppFeeChange2017.aspx

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disclose the ownership or control information described in Title 42, CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42, CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal Program. These disclosures must be provided when:

- A prospective provider submits the provider enrollment application.
- A provider executes the DHCS Provider Enrollment Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[13]

Additionally, MCPs must comply with the requirements contained in Title 22, CCR, Section 51000.35, Disclosure Requirements. MCPs are not required to utilize the DHCS disclosure forms (DHCS 6207 and 6216[14]); however, MCPs must collect all information and documentation required by Title 22, CCR, Section 51000.35.

D. "Limited," "Moderate," "High" Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as "limited," "moderate," or "high." If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening requirements and for MCPs to stratify their network providers by risk level are set forth in Attachment 1 to this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs are

[13] 42 CFR 455.105(b)
[14] DHCS Forms 6207 and 6216 are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

not able to enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements.
- Hold a license certified for practice in the state and has no limitations from other states.
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers:

- Screening requirements of limited-risk providers.
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers.
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers - Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a

5% or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[15] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. DHCS will make a pre-filled Live Scan form available to all MCPs to distribute to providers. When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22, CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. In addition, all providers enrolled in the Medi-Cal Program, including providers enrolled through MCPs,[16] are subject to unannounced onsite inspections at all provider locations.

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal Program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[15] Welfare and Institutions Code 14043.38(c)(2)
[16] 42 CFR 455.432

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G. Federal and State Database Checks

During the provider enrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File.[17]
- National Plan and Provider Enumeration System (NPPES).[18]
- List of Excluded Individuals/Entities (LEIE).[19]
- System for Award Management (SAM).[20]
- CMS' Medicare Exclusion Database (MED).[21]
- DHCS' Suspended and Ineligible Provider List.[22]

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal Managed Care Program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment, that may impact the provider's eligibility to participate in the Medi-Cal Program, or a provider refuses to submit to the required screening activities,[23] the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal Program.

If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[24]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[25]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and

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[17] Social Security Administration's Death Master File is available at: https://www.ssdmf.com/
[18] NPPES is available at: https://nppes.cms.hhs.gov
[19] LEIE is available at: https://oig hhs.gov/exclusions/exclusions_list.asp
[20] SAM is available at: https://www.sam.gov
[21] MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html
[22] Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[23] 42 CFR 455.416
[24] Provider Enrollment information can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx.
[25] 42 CFR 455.422

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DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement (Attachment 2), which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment 2. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- Notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through the DHCS' Medi-Cal FFS provider enrollment process.
- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS Program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their limited-risk and medium-risk network providers at least every five years,[26] and their high-risk network providers every three years. MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

[26] 42 CFR 455.414

Data Base Checks
MCPs must review the SAM and LEIE databases on a monthly basis. All other databases must be reviewed upon a provider's reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal Programs; any provider terminated from the Medicare or Medicaid/Medi-Cal Program may not participate in the MCP's provider network.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[27] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process, in accordance with Title 42, CFR, Section 438.602(b)(2).

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements

MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing

[27] 42 CFR 438.3(u)

body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing

MCPs are required to verify the credentials of their contracted medical providers, and to verify the following items, as required for the particular provider type, through a primary source,[28] as applicable:[29]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[30]

[28] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[29] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.
[30] National Practitioner Data Bank is available at: https://www ncsbn.org/418.htm.

- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List may not participate in the MCP's provider network.[31]
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

Attestations

For all medical service provider types who deliver Medi-Cal-covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[32]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities serious quality deficiencies that result in suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites. For detailed guidance, see Policy Letter (PL) 14-004, Site Reviews, Facility Site Review and Medical

[31] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

[32] These limited statements comply with requirements of the Americans with Disabilities Act (ADA), as discussed in the attached PL 02-03. The ADA Attachment is available at (pg. 7): http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf.

Record Review,[33] and any subsequent revisions to this PL. MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. MCPs; however, retain overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

[33] Policy Letter 14-004 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf

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MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including applicable APLs, PLs and Dual Plan Letters. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

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Attachment 1: Provider Types and Categories of Risk[34]/Screening Requirements

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities

[34] CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations

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- Non-public, non-government owned or affiliated ambulance services suppliers
    - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.

(3) High Risk Provider Types. Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.

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Attachment 2: Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

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application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.

- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS.

- The provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2010
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Authorize Revisions to Credentialing and Provider Participation Requirements in CalOptima's Medi-Cal Program

Contact

Gertrude S. Carter, M.D., Chief Medical Officer, (714) 246-8400
Greg Buchert, M.D., MPH, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Approve policy continuing the requirement that providers furnishing services to CalOptima Medi-Cal members be enrolled in the State of California Medi-Cal Program when enrollment is available for that type of provider;
2. Approve an exception to that Policy for providers outside of Orange, Los Angeles, San Bernardino, Riverside and San Diego Counties;
3. Approve policy that the Chief Medical Officer or delegate, and delegated providers have the ability to make exceptions to the policy identified in Recommended Action No. 1 to satisfy access and continuity of care requirements in CalOptima's contract with the California Department of Health Care Services (DHCS);
4. Approve policy that providers credentialed by CalOptima or its delegated providers that furnish services, goods or supplies to Healthy Families or OneCare members are encouraged, but not required to, enroll in the State of California Medi-Cal program;
5. Eliminate the Minimum Practitioner Standards (MPS) Policy and requirement for applicable physicians to complete the MPS form prior to credentialing; and,
6. Approve changes to CalOptima's policies to reflect the changes made in this CalOptima Board Action Agenda Referral.

Background

CalOptima contracts directly with providers, or with delegated entities to arrange for providers, to render services to its members. For CalOptima's Healthy Families and OneCare programs, the providers' qualifications are evaluated by standardized credentialing processes that are consistent with NCQA standards and if deemed qualified, can provide services and bill for those services. CalOptima requires the California Department of Health Care Services (DHCS) statutory process related to authorized categories of persons and entities that provide services, goods, and supplies to Medi-Cal recipients. The State process is intended to ensure that provider practices are consistent with sound fiscal and business practices and do not result in unnecessary cost to the State Medi-Cal program and that the State/CalOptima do not have to reimburse the State or CMS for ineligible providers. The State also requires that a provider meet federal disclosure requirements including, without limitation, those related to the provider's licensure, control and ownership interests, and health care program participation status. In reviewing

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provider applications, the State has the authority to conduct unannounced visits, pre-enrollment inspections, background checks and access government resources related to convictions, pending investigations and the status of debts and penalties, if any, owed to government entities.

The State has also established enrollment moratoriums related to specific provider types throughout the State or within specific counties in order to "safeguard public funds and maintain the fiscal integrity of the Medi-Cal program." For example, the State has a moratorium on enrollment of durable medical equipment suppliers (with exceptions) that expressly includes Orange, Los Angeles, Riverside and San Bernardino Counties. Significantly, the State provider enrollment laws incorporate the State's right to summarily deny or suspend a provider's enrollment status, for example, where there are pending allegations of fraud or abuse or investigations related to same.

Prior to January 1, 2009, CalOptima's State Medi-Cal contract with the DHCS required that "each provider who delivers Covered Services to Members shall *be eligible* for participation in the Medi-Cal program and shall meet applicable requirements established under Titles XVIII and XIX of the Social services Act unless exempted from these provisions." The State's enrollment process may take as long as twelve months for a provider to receive acknowledgement of enrollment. While most providers complied with this requirement, some providers discontinued attempting to be paid for services rendered or refused to provide future services to CalOptima members.

In addition to standard credentialing requirements for all providers and the supplemental Medi-Cal enrollment procedure for providers in certain CalOptima medical delivery systems, CalOptima initiated a requirement for providers to supply additional information in order to be paid by CalOptima – the Minimum Practitioner Standards (MPS) form based on the CalOptima Board-approved policy. This policy was adopted in part to allow for a contracted COD network and to provide a basis of denying provider participation without the necessity of a formal statutorily-required hearing for providers who could not meet the standards. All questions of this seven question form request identical information that is included on credentialing applications. Eliminating the MPS form may result in the CalOptima having to file a notice to the Medical Board of California (an "805" report) for COD or Hospital Risk providers in the Medi-Cal program for which CalOptima takes certain actions based on a medical or disciplinary cause or reason. This requirement already exists for PHCs, HMOs, and SRGs in the CalOptima Healthy Families and OneCare programs.

CalOptima entered into a new State Medi-Cal contract with DHCS on January 1, 2009. The contract *no longer* includes language requiring "each provider who delivers Covered Services to Members shall be eligible for participation in the Medi-Cal program and shall meet applicable requirements established under Titles XVIII and XIX of the Social Services Act unless exempted from these provisions." The new 2009 State Medi-Cal contract also includes the following language: "Nothing in this provision shall be construed to require that subcontracting providers be enrolled as a Medi-Cal provider." The new State Medi-Cal contract does incorporate a

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Prepaid Health Plan statute which expressly prohibits contracts between DHCS and PHPs "unless the providers and the facilities of the prepaid health plan meet the Medi-Cal program standards for participation as established by the director." Based on the contract language and communications with the State, CalOptima Staff understands that its providers do not have to enroll with the State Medi-Cal provider enrollment unit.

CalOptima continues to have obligations to ensure that providers furnishing covered items and services to CalOptima members are contracted and meet federal and state requirements through a standardized credentialing process, including providers who cannot enroll with Medi-Cal (e.g., Health Educators, Dieticians, providers subject to DHCS moratorium, and in-home service providers).

Discussion

CalOptima is responsible for providing access to qualified providers to its members through a standard credentialing process that includes evaluation of many items relevant to quality, integrity and licensure. The attached table compares the differences between those activities that are consistently performed as part of the CalOptima credentialing programs at either CalOptima or by its delegated entities with activities that may occur during the DHCS enrollment process.

Primary care providers in the CalOptima Medi-Cal program also have stringent DHCS defined facility site reviews that include both an inspection of the physical space and evaluation of adherence to certain standards, as well as an evaluation of medical record documentation practices. CalOptima's credentialing process and those of its delegated networks are audited on a routine basis by DHCS, the California Department of Managed Health Care (DMHC) and the Centers for Medicare & Medicaid Services (CMS).

For those providers that enroll with the Medi-Cal program, CalOptima benefits from that process which similarly screens potential CalOptima providers for applicable State and federal requirements and makes ultimate determinations on participation in the Medi-Cal program. Unlike the State, CalOptima does not have similar legal authority or resources to conduct the certain pre-screening and investigative activities related to provider enrollment nor does it have the same statutory authority to summarily suspend providers based on pending investigations and other matters. This responsibility and associated risk will be assumed by CalOptima for certain providers for provision of Medi-Cal services if it does not continue to require Medi-Cal enrollment for excepted providers.

While CalOptima strives to assure providers are qualified to provide services to its Medi-Cal members, it also strives to assure that its members are able to gain access to and have choice of the largest number of providers possible. While there are many CalOptima Direct providers that are currently enrolled in the Medi-Cal program, some are not, and to complete a contracted network, CalOptima needs the flexibility to make exceptions to these enrollment requirements to satisfy its access and continuity of care obligations under its contract with DHCS.

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CalOptima believes that, of the number of active licensed providers (Physicians, Podiatrists, Nurse Practitioners, Optometrists) in Orange County, approximately half are not enrolled in the Medi-Cal program although it is possible that some of these providers may not be entitled to directly bill the Medi-Cal program. The majority of providers that do not enroll in the Medi-Cal program elect to maintain that status for a variety of reasons (including desire to limit their Medi-Cal patients in their practice and avoid the lengthy application process), hence, become unavailable to serve CalOptima Direct and network members, yet they are still eligible to provide services to OneCare and Healthy Families members. Often times, providers who participate in OneCare or Healthy Families will also render services to CalOptima members because they are not aware of the different requirements for each line of business and they are frustrated by the delay or denial of payment for lack of Medi-Cal enrollment.

This policy would exempt providers outside Los Angeles, San Bernardino, Riverside, San Diego and Orange Counties from being enrolled with Medi-Cal or credentialed by CalOptima to be paid by CalOptima for rendering services to its members. It would also allow CalOptima's Chief Medical Officer, and delegated providers in conjunction with the Chief Medical Officer, to use providers who are not enrolled with Medi-Cal to satisfy CalOptima's State Contract requirements to provide proper access to, and continuity of, care for members. Examples of such exemptions may include providers in certain geographic areas which do not have adequate enrolled providers; providers that have unique needed clinical expertise; and providers who see less than five members in a calendar year. These types of providers will still be credentialed by CalOptima and may, in addition, have applications for enrollment in Medi-Cal pending.

In adopting this policy, CalOptima will assume additional responsibilities and liabilities. CalOptima must monitor anti-discrimination; be responsible for provider disciplinary matters; increase screening of providers presently done by Medi-Cal as a part of enrollment compliance; monitor federal/state requirements of its non-enrolled providers including fraud and abuse; and risk of challenge by providers not exempted from the requirement. The monitoring requirements assumed by CalOptima may present problems since DHCS will have limited jurisdiction for any fraud and abuse referrals related to non-enrolled providers. CalOptima has limited ability to investigate, and it cannot prosecute suspected fraud. CalOptima will have to rely on referring such matters to the Attorney General, District Attorney or the applicable State Licensing Board, which may lead to additional costs to investigate and additional risk of investigation or penalty to CalOptima of being out of compliance until the issue is resolved.

Notwithstanding these risks, Management makes the recommended actions outlined in this report to allow required access to providers for CalOptima Medi-Cal members while continuing to require the Medi-Cal enrollment process for the reasons stated herein. CalOptima would have to submit any changes to its provider participation requirements and related policies to DHCS for approval.

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Fiscal Impact

For both medical and administrative expenses, the fiscal impact of this action on the CalOptima budget is not known. For medical expenses, a small number of providers may currently be seeing CalOptima members but not submitting claims because they are not enrolled in the Medi-Cal program. However, neither the number of unsubmitted claims nor the associated dollars are estimated to be material. For additional administrative expenses, management anticipates that they will be absorbed into the Board-approved budget. Such expenses are dependent on several factors. For example, there may be new administrative responsibilities due to the need for CalOptima to take on additional levels of review related to provider enrollment requirements that are not currently part of CalOptima's credentialing program. Also, CalOptima's Compliance Department may have increased obligations and incur additional costs due to the DHCS' Audits & Investigations Unit (A&I) not having jurisdiction over non-enrolled providers should CalOptima identify potential fraud and/or abuse involving non-enrolled providers. Staff will monitor medical and administrative expenses and keep the Board apprised should they prove to be greater than anticipated.

Rationale for Recommendation

Notwithstanding the additional risk and possible administrative costs to CalOptima in allowing exceptions to Medi-Cal enrollment, the recommendations, if adopted, will allow CalOptima expanded access to quality health care service providers consistent with the State Contract who are not presently enrolled in the Medi-Cal program.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachment

Medi-Cal Enrollment and CalOptima Contracting and Credentialing Comparison

/s/ Richard Chambers — *10/1/2010*

Authorized Signature — **Date**

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Medi-Cal Enrollment and CalOptima Contracting and Credentialing Comparison

Category	Item	DHCS FFS	CalOptima Contracted
Information Collected	All Providers	Business Location	Business Location
		Tax ID Number	Tax ID Number
		Licenses	Licenses
		Proof of Insurance	Proof of Insurance
		Business License	*
		Seller's Permits (if req.)	*
		Fictitious Business Name Statement (if app.)	*
		Fines or Debts Owed to Govt. Healthcare Programs	*
		Felony convictions in last ten years	Felony convictions in last ten years
		Misdemeanor convictions involving fraud/abuse in last ten years	*
		Civil liability involving fraud/abuse in last ten years	*
		Settlements in lieu of conviction for fraud/abuse in last ten years	*
		Suspensions from Medi-Cal/Medicare/Medicaid	Suspensions from Medi-Cal/Medicare/Medicaid
		Suspensions/Revocations of license/certificate/approval to provide health care	Suspensions/Revocations of license/certificate/approval to provide health care
		Lost or surrendered license/certificate/approval to provide health care with discipline pending	Lost or surrendered license/certificate/approval to provide health care with discipline pending
		History of discipline re: license/certificate/approval to provide health care	History of discipline re: license/certificate/approval to provide health care
		Ownership/management/control	*
		Subcontractor information	*
		Subcontractor ownership/management/control if over $75K over five years	*
	Group Practices	Group type and specialties	Group type and specialties
		Rendering providers	Rendering providers
		Hospital privileges of rendering providers	
		Suspended or revoked hospital privileges of rendering providers	
		Voluntary resignation or surrender of hospital privileges by rendering providers	
		CLIA certificate number	
		State laboratory license/registration number	

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Category	Item	DHCS FFS	CalOptima Contracted
		Rendering provider application for providers not already enrolled	
		partnership agreement, if partnership	
	Physicians	CLIA certificate number	
		State laboratory license/registration number	
		Hospital privileges	Hospital privileges
		Suspended or revoked hospital privileges	Suspended or revoked hospital privileges
		Voluntary resignation or surrender of hospital privileges	Voluntary resignation or surrender of hospital privileges
			Other previous hospital privileges
			Premed Education
			Medical education
			Internship/PGYI
			Residencies/Fellowships
			Board Certifications
			Other Certifications
			Other state licenses
			Peer references
			Work history
			Student status relinquishment
			Professional organization discipline
			Drug-related impairment
			Disability accommodation
			Malpractice judgments/settlements
			Professional liability insurance termination/non-renewal
	Rendering Providers	Payment arrangement documents	No separate requirements
		DEA certificate	
		Anesthesia permit	
		Conscious sedation permit	
	Hospital-Based Physician	CLIA Certificate number	Exempted
		State laboratory license/registration number	

Category	Item	DHCS FFS	CalOptima Contracted
Independent Verification	As applicable	Professional licensure	Professional licensure
		Criminal history--Applicant, provider and all ownership and control persons	
		Suspensions from government programs	Suspensions from government programs
		Professional discipline	Professional discipline
		Compliance with definition (22 CCR Art. 2, Ch. 3)	
		Compliance with Standards (22 CCR Art.3, Ch. 3 and W&I Ch. 7 and Ch. 8)	
		Business licenses	
		Payment of all outstanding fines and debts to government programs	
		Current FWA investigation status of applicant, providers and all ownership and control persons	
		Onsite inspection	Onsite inspection
		No denial of enrollment in last three years	
			Hospital privileges
			Education
			Board certification
			DEA Certification
			Malpractice claim history
Enforcement Tools	All	Referral to law enforcement	Referral to law enforcement
		Contract remedies	Contract remedies
		Recoupment of Overpayments	Recoupment of Overpayments
		Civil monetary penalties	
		Peace officer status employees in Audits and Investigations	
		Summary deactivations	
		Summary terminations of provisional and preferred provisional providers	
		Sanctions (reprimand/probation/suspension)	

* CalOptima's contract with DHCS requires CalOptima to collect current, completed DHCS Disclosure Form from each subcontractor containing this information.

Credentialing and Provider Participation Requirements

Board of Directors Meeting
October 7, 2010

Gertrude S. Carter, M.D.
Chief Medical Officer

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Medi-Cal Participation History

- Requirement based on Fee-for-Service (FFS) Medi-Cal requirements

- Administrative and business focused assessment
  - Example: location, licensure status, provider's legal standing (see grid)

- FFS Medi-Cal needs:
  a. Screening mechanism to ensure minimum participation standard
  b. Means to facilitate payment
  c. Capability to monitor and enforce legal requirements

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CalOptima Participation History

- CalOptima currently requires Medi-Cal participation

- CalOptima credentialing process includes Medi-Cal participation, administrative and business requirements plus significant clinical and quality requirements.
  - Credentialing includes:
    - Education, board certification, affiliation/privileges and clinical performance
    - Facility site review and medical record review

- Former DHCS Contract stated: “Provider shall be eligible for participation in the Medi-Cal Program.”

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Current CalOptima Contract

- Current updated Medi-Cal contract language clarifies DHCS position:
  - Exhibit A, Attachment 6 (Provider Network), Provision 12 (Subcontracts)

    "Contractor shall remain accountable for all functions and responsibilities that are delegated to subcontractors. Nothing in this provision shall be construed to require that subcontracting providers be enrolled as a Medi-Cal provider."

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Issue

- What should the policy be in those cases where compliance with both requirements are in conflict, specifically when access and quality cannot be met within a Medi-Cal enrolled network?
  - ➢CalOptima has an informal process that is based on medical necessity
  - ➢The informal “exception” policy is not consistent with the current participation policy

Exceptions

- Geographic
  - Availability of service in geographic area
- Clinical service
  - Access to the most appropriate level of experience available
- Continuity of care
  - Maintaining on-going treatment plan
- Member specific need that can drive clinical outcomes
  - Culture
  - Religion
  - Gender

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Analysis 2009

- COD Prior Authorization = 30,000

- Letters of Agreement = 906
  - Ambulatory Surgery Centers = 591
  - Hospitals = 197
  - Other Facilities = 50
  - Professional Services = 56
  - Other = 12

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Analysis 2009

- Historical (Non Medi-Cal enrolled providers)
  - ➢COD (Registered) = 163 of 4,647 total contracted providers = 3.5%
  - ➢Noble = 9 of 369 total contracted providers = 2.4%
  - ➢CHOC Health Alliance = 6 of 688 total contracted providers = 0.9%
  - ➢Monarch = 72 of 1,532 total contracted providers = 4%

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Risk

- CalOptima would have to assume legal and enforcement functions without the State's police powers for those non- Medi-Cal enrolled providers, just as with all other lines of business

- Poses minimum risk because:
  1. Credentialing process
  2. Primary focus is high complex specialty directed providers who have affiliations with tertiary facilities
  3. Low utilization of exceptions
  4. CalOptima oversight activities including both compliance and peer review

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Recommendation

Align the informal process with current policy to continue Medi-Cal participation with exceptions that promote access and quality based on medical necessity review.

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CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
6. Consider Revisions to Policy FF.1005c: Special Payments: High Cost Exclusion Items

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

Recommended Actions
Authorize modification of CalOptima Medi-Cal Policy FF.1005c Special Payments: High Cost Exclusion Items as follows:

1) Eliminate previous carve-out for services paid under the California Children's Services (CCS) Program;
2) Implement a new procedure to require the submission of a remittance advice for qualifying services provided for PHC and HMO members; and
3) Clarify that such payments are paid to a contracted hospital for qualifying outpatient services, and qualifying inpatient services paid on a per diem basis.

Background
CalOptima established a policy in 2005 to pay supplemental payments to all CalOptima contracted hospitals for the cost of unusually expensive surgical implants and other items that caused hospital stay costs to significantly exceed average per diem rates. The supplemental payments were for inpatient implants, biologics, high cost pharmaceuticals, orthotics, and prosthetics whose invoice cost exceeded $2,500, and were reimbursed at the invoice cost plus five percent, minus a $1,500 deductible per item. The policy was revised in 2008 to lower the threshold from $2,500 to invoice cost that exceeded $500 with the invoice being reimbursed at 100%, minus a $500 deductible. Hospital services paid for on an All Patient Refined Diagnosis Related Group (APR-DRG) basis are excluded from the policy because the APR-DRG methodology already provides for outlier payments which are intended to capture these costs. The policy also provides for supplemental payments for the same qualifying services provided on an outpatient basis. The policy excluded those qualifying services paid for by the CCS Program.

Discussion
With the integration of the CCS program into CalOptima through the Whole-Child Model (WCM), effective January 1, 2019, staff is recommending that the Board authorize removing the exclusion for High Cost Exclusion items previously provided to CalOptima Members under the CCS Program.

In addition, in order to better manage this process going forward, staff recommends modifying the process by which hospitals are reimbursed for qualifying services provided to members assigned to CalOptima's HMOs or Physician-Hospital Consortium (PHC) health networks. CalOptima pays hospitals through CalOptima's claims payment system, FACETS, for qualifying services provided to members assigned to CalOptima Direct (COD) and CalOptima's Shared Risk Group (SRG) health networks. Because CalOptima is paying for the underlying hospital services, we know whether a hospital is being paid on a per diem basis, which is a requirement under the High Cost Exclusion

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policy. That is not the case for qualifying services provided to a PHC and HMO members. In both of those situations, the PHC or HMO pays for the underlying hospital services. The hospital providing the services then requests the supplemental payment from CalOptima after the fact. Consequently, staff recommends including a requirement that, in order for a hospital to receive additional reimbursement under the High Cost Exclusion policy, it must submit a copy of the remittance advice from the PHC or HMO to validate that any qualifying services were reimbursed on a per diem basis as required by the policy.

Staff also recommends adding language to the policy to clarify that outpatient services are eligible for the High Cost Exclusion policy even if the hospital is contracted on an APR-DRG basis.

Fiscal Impact

The recommended actions to modify CalOptima's Medi-Cal Policy FF.1005c Special Payments: High Cost Exclusion Items is a budgeted item, with no anticipated additional fiscal impact. Total high costs exclusions paid for PHC and HMO Members are projected to be $2.5 million annually. The proposed policy revisions are not expected to result in a material increase to the cost of high cost exclusion items. Management has included projected medical and administrative expenses associated with the policy in the CalOptima Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018. Staff expects the budgeted expenses to be sufficient to cover the costs resulting from the proposed policy revisions.

Rationale for Recommendation

With the integration of the CCS Program into CalOptima, the previous exclusion is no longer necessary. As for the change to the claims submission process for qualifying services provided to HMO and PHC members, the procedure will ensure that CalOptima will be able to continue to meet the goals of the High Cost Exclusion program, while avoiding the possibility of making double payments to hospital providers who have already been fairly compensated for high cost inpatient procedures through the APR-DRG system or through procedure-specific case rates.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Policy FF.1005c. Special Payments: High Cost Exclusions Items (redlined and clean versions)

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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Policy #:	FF.1005c
Title:	**Special Payments: High Cost Exclusion Items**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/07
Last Review Date:	10/04/18~~11/01/16~~
Last Revised Date:	10/04/18~~11/01/16~~

I. PURPOSE

This policy describes the process by which CalOptima shall reimburse a Contracted Fee-For-Service (FFS) Hospital for a High Cost Exclusion Item provided to a Medi-Cal Member as part of outpatient services, or inpatient services paid on a per diem basis.

II. POLICY

A. CalOptima shall reimburse a Contracted FFS Hospital for a High Cost Exclusion Item provided to a Member in an inpatient or outpatient setting, in accordance with this policy, subject to the availability of funding as established by the CalOptima Board of Directors.

B. A High Cost Exclusion Item is any of the ~~following~~ Covered Services ~~that are not reimbursed~~identified in ~~the case rate~~this Policy for which a ~~specific procedure~~Hospital contracted with CalOptima is paid by CalOptima, a Health Care Services Plan (HMO) Health Network, or ~~that are excluded from a Contracted FFS Hospital's~~Physician-Hospital Consortium (PHC) Health Network for outpatient ~~reimbursement~~services or for inpatient services paid on a per diem ~~rate:~~basis.

C. High Cost Exclusion items include the following categories:

1. Implantable device~~;~~
2. Biologic;
3. High-cost pharmaceutical – individual ingredient per dose of a pharmaceutical agent;
4. Orthotic; or
5. Prosthetic.

~~C.~~D. A hospital is eligible for reimbursement for a High Cost Exclusion Item if such hospital is a Contracted FFS Hospital on the date that it provides such High Cost Exclusion Item to a Member.

~~D.~~E. CalOptima shall reimburse a Contracted FFS Hospital for a High Cost Exclusion Item provided to a Member if:

1. CalOptima~~,~~ or the Member's Health Network~~,~~ authorized the provision of such High Cost Exclusion ~~Items~~Item(s) to the Member;

2. The invoice cost of all items of the same Covered Service category, as specified in Section II.~~B~~C. of this policy, provided during a single procedure total at least five hundred dollars ($500); and

3. The Contracted FFS Hospital submits a claim, in accordance with Section III of this policy, within three hundred and sixty-five (365) calendar days for dates of service on or after July 1, 2013.

~~E.~~F. CalOptima shall reimburse a Contracted FFS Hospital the total manufacturer's invoice cost of all High Cost Exclusion Items in the same category provided during a single procedure, less the deductible and any amounts paid for the High Cost Exclusion Items through the regular claims payment process.

1. Effective October 1, 2010: Deductible = $500 (high-cost pharmaceutical applied per dose, as defined in Section II.~~B~~C.3. of this policy).

2. CalOptima's reimbursement amount shall be solely based on the manufacturer's invoice submitted by the Contracted FFS Hospital.

~~F.~~G. . Effective with dates of service January 1, 2019, CalOptima shall ~~not~~ reimburse a Contracted FFS Hospital for a High Cost Exclusion Item provided to a Member who is admitted to the Contracted FFS Hospital for a California Children Services (CCS)-Eligible Condition.

~~G.~~H. The four (4) digit Revenue Codes that are potentially eligible for additional payment under this policy include:

1. 0250 – Pharmacy – General Classification;

2. 0251 – Pharmacy – Generic Drugs;

3. 0252 – Pharmacy – Non-Generic Drugs;

4. 0253 – Pharmacy – Take Home Drugs;

5. 0254 – Pharmacy – Drugs Incident to other Diagnostic Services;

6. 0255 – Pharmacy – Drugs Incident to Radiology;

7. 0257 – Pharmacy – Non-Prescription;

8. 0258 – Pharmacy – IV Solutions;

9. 0259 – Pharmacy – Other Drugs/Other;

10. 0270 – Medical Surgical Supplies;

11. 0272 – Sterile Supplies;

12. 0274 – Prosthetic/Orthotic Devices;

13. 0275 – Pacemaker;

14. 0276 – Intraocular Lens;

15. 0278 – Other Implants;

16. 0279 – Other Supplies/Devices;

17. 0634 - Pharmacy – Erythropoietin (EPO) less than 10,000 units;

18. 0635 – Pharmacy - Erythropoietin (EPO) greater than 10,000 units; and

19. 0636 – Pharmacy – Drugs Requiring Detailed Coding.

~~H.~~I. A Contracted FFS Hospital shall submit claims for High Cost Exclusion Items in accordance with the terms of this policy.

III. PROCEDURE

A. A Contracted FFS Hospital shall submit a separate invoice for each category of High Cost Exclusion Item per procedure for which it is seeking reimbursement.

B. A Contracted FFS Hospital shall include in a single claim all High Cost Exclusion Items in the same category provided during a procedure.

~~C. If a Contracted FFS Hospital provides a High Cost Exclusion Item to a Member:~~

C. For claims related to High Cost Exclusion Items provided by a Contracted FFS Hospital to a CalOptima Member who is assigned to CalOptima Direct or a Shared Risk Health Network, the claim for High Cost Exclusion payment, containing the documentation identified in Section III.D.2.a.-d. of this Policy, may be included with the regular UB-04 claim for services, or may be submitted as provided in Section III.D.

D. For claims related to High Cost Exclusion Items provided by a Contracted FFS Hospital to a CalOptima Member who is assigned to an HMO or PHC Health Network:

1. The Contracted FFS Hospital shall submit a claim for reimbursement of the High Cost Exclusion Item to CalOptima at:

   Attention: Special Claims Unit
   CalOptima
   505 City Parkway West
   Orange, CA 92868

2. The Contracted FFS Hospital shall submit a claim with the following:

   a. Original, or copy, of the UB04 form documenting itemization of the High Cost Exclusion Item;

   b. High Cost Exclusion Item to be billed using the eligible Revenue Code as indicated in Section II.~~G~~H. of this policy;

c. A copy of the manufacturer's invoice for the High Cost Exclusion Item supported by itemized statement and/or implant log; and

d. A copy of the authorization for the procedure and the High Cost Exclusion Item.

e. A copy of the remittance advice for payment of the UB-04 form on which the High Cost Exclusion Items appear.

~~D.~~E. CalOptima shall adjudicate a Clean Claim for a High Cost Exclusion Item within thirty (30) calendar days after receipt of such Clean Claim.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
~~C. CalOptima Policy AA.1000: Glossary of Terms~~
~~D.~~C. This policy supersedes Financial Bulletin #37: Exclusions from hospital inpatient per diem rates; high cost items

VI. REGULATORY AGENCY APPROVALS

A. 09/21/15: Department of Health Care Services
B. 01/14/11: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
B. 03/06/14: Regular Meeting of the CalOptima Board of Directors
C~~B~~. 12/04/08: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	FF.1005c	Special Payments: High Cost Exclusion Items	Medi-Cal
Revised	01/01/2009	FF.1005c	Special Payments: High Cost Exclusion Items	Medi-Cal
Revised	10/01/2010	FF.1005c	Special Payments: High Cost Exclusion Items	Medi-Cal
Revised	07/01/2014	FF.1005c	Special Payments: High Cost Exclusion Items	Medi-Cal
Revised	11/01/2016	FF.1005c	Special Payments: High Cost Exclusion Items	Medi-Cal
Revised	10/04/2018	FF.1005c	Special Payments: High Cost Exclusion Items	Medi-Cal

1
2

III. GLOSSARY

Term	Definition
California Children's Services Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
Clean Claim	A claim that can be processed without obtaining additional information from the provider of the service or from a third party.
Contracted Fee-For-Service (FFS) Hospital	A hospital that has entered into a CalOptima Hospital Services Contract to provide Hospital Services to CalOptima Members.
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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.
High Cost Exclusion Item	Specific high-cost items that are excluded from a Contracted Hospital's outpatient reimbursement or inpatient per diem rate.
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.

Policy #:	FF.1005c
Title:	**Special Payments: High Cost Exclusion Items**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/07
Last Review Date:	10/04/18
Last Revised Date:	10/04/18

I. PURPOSE

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A. CalOptima shall reimburse a Contracted FFS Hospital for a High Cost Exclusion Item provided to a Member in an inpatient or outpatient setting, in accordance with this policy, subject to the availability of funding as established by the CalOptima Board of Directors.

B. A High Cost Exclusion Item is any of the Covered Services identified in this Policy for which a Hospital contracted with CalOptima is paid by CalOptima, a Health Care Services Plan (HMO) Health Network, or Physician-Hospital Consortium (PHC) Health Network for outpatient services or for inpatient services paid on a per diem basis.

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1. Implantable device
2. Biologic;
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1. CalOptima or the Member's Health Network authorized the provision of such High Cost Exclusion Item(s) to the Member;
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   b. High Cost Exclusion Item to be billed using the eligible Revenue Code as indicated in Section II.H. of this policy;

   c. A copy of the manufacturer's invoice for the High Cost Exclusion Item supported by itemized statement and/or implant log; and

d. A copy of the authorization for the procedure and the High Cost Exclusion Item.

e. A copy of the remittance advice for payment of the UB-04 form on which the High Cost Exclusion Items appear.

E. CalOptima shall adjudicate a Clean Claim for a High Cost Exclusion Item within thirty (30) calendar days after receipt of such Clean Claim.

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Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
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Effective	01/01/2007	FF.1005c	Special Payments: High Cost Exclusion Items	Medi-Cal
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Revised	11/01/2016	FF.1005c	Special Payments: High Cost Exclusion Items	Medi-Cal
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High Cost Exclusion Item	Specific high-cost items that are excluded from a Contracted Hospital's outpatient reimbursement or inpatient per diem rate.
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.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Authorizing an Amendment to Amend and Extend the Coordination and Provision of Public 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 enter into an amendment to the Coordination and Provision of Public Health Care Services Contract (Contract) with Orange County Health Care Agency (HCA) to extend the contract for five (5) years, through December 31, 2023, and update contract language to address programmatic and regulatory changes as summarized below.

Background

HCA provides various public health programs to Medi-Cal members, as provided under State law, including various clinical services. CalOptima entered into several Memoranda of Understanding (MOUs) from 1996 through 2004, to delineate the roles and responsibilities between CalOptima and the HCA as they relate to coordination of care and payment for certain services, so that full cooperation could be achieved between the two organizations through collaboration, communication, and free exchange of information.

The Contract was originally effective June 1, 2013, following Board action taken on May 2, 2013, to combine the following MOUs into one contract as required by CalOptima's contract with the California Department of Health Care Services (DHCS):

1. Child Health and Disability Prevention Program (CHDP)
2. California Children's Services (CCS)
3. HIV Programs & HIV Clinic Services
4. Immunization Assistance Project (IAP)
5. Juvenile Health Services-Orangewood (JHS-Orangewood)
6. Maternal, Child & Adolescent Health Program (MCAH)
7. Pulmonary Disease Services (PDS)
8. Sexually Transmitted Diseases Clinical Services

Thereafter, the Contract was amended effective July 1, 2015, following Board action on September 3, 2015, to incorporate coordination of Targeted Case Management requirements as specified by DHCS. It was subsequently amended effective July 1, 2018 following Board action taken June 7, 2018, to extend the Contract for six (6) months while contract language changes are finalized. The Contract currently expires on December 31, 2018.

Back to Agenda

Discussion

As proposed, the amendment would extend the Contract for five (5) years and update contract language including;

1. Identifying the CHDP claim form transition from the PM-160 form to the CMS-1500 or UB-04 forms or electronic equivalent, as applicable, per DHCS instruction;
2. Referencing the separate CCS MOU between CalOptima and HCA that will be effective January 1, 2019[GE1];
3. Incorporating applicable Medicaid Managed Care Final Rule (Mega Reg) requirements.
4. Updating billing and payor information to be consistent with the Medi-Cal Matrix of Financial Responsibility in CalOptima's health network contracts to reflect that HCA is to bill health networks for members assigned to health networks for:
    a. Adult Immunizations
    b. Pediatric Preventative Services (PPS), including PPS services provided at Orangewood

Fiscal Impact

The recommended action to execute an amendment to the Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency is a budgeted item with no additional fiscal impact. Management has included expenses associated with the extended Contract in the consolidated CalOptima Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue CalOptima's contractual relationship with the Orange County Health Care Agency, and to comply with DHCS contract requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated June 7, 2018, Consider Authorizing an Amendment to Extend the Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency
    a. Board Action dated May 2, 2013, Authorize the Chief Executive Officer to Execute the "Coordination and Provision of Public Health Care Services Contract" with the Orange County Health Care Agency
    b. Board Action dated September 3, 2015, Authorize the Chief Executive Officer to Execute an Amendment to Contract with the Orange County Health Care Agency for the Coordination of Targeted Case Management

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
36. Consider Authorizing an Amendment to Extend the Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency

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

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to execute an amendment to the Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency (County) to extend the contract for six (6) months, while contract language changes are finalized.

Background
County provides various public health programs to Medi-Cal members, as provided under State law, including various clinical services. CalOptima completed several MOUs beginning in 1996 through 2004, to delineate the roles and responsibilities between CalOptima and County as they relate to coordination of care and payment for certain services, so that full cooperation could be achieved between the two agencies through collaboration, communication, and free exchange of information.

The Coordination and Provision of Public Health Care Services Contract (Contract) was put in place on June 1, 2013, following Board Authority on May 2, 2013, to combine the following MOUs into one contract:

1. Child Health and Disability Prevention Program (CHDP)
2. California Children's Services (CCS)
3. HIV Programs & HIV Clinic Services
4. Immunization Assistance Project (IAP)
5. Juvenile Health Services-Orangewood (JHS-Orangewood)
6. Maternal, Child & Adolescent Health Program (MCAH)
7. Pulmonary Disease Services (PDS)
8. Sexually Transmitted Diseases Clinical Services

The Contract updated coordination of care and payment of services information specific to the certain services provided by County and allowed CalOptima to be in compliance with the California Department of Health Care Services (DHCS) contract in regards to having a contract in place instead of an MOU for health care covered services that are reimbursed by CalOptima.

The Coordination and Provision of Public Health Care Services Contract was amended on July 1, 2015, following Board Authority September 3, 2015, to incorporate coordination of Targeted Case Management requirements as specified by DHCS.

The Contract expires on July 1, 2018.

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Discussion

The six (6) month extension to the Contract will ensure that the roles and responsibilities between CalOptima and County continue to finalize Contract language, including but not limited to:

1. CHDP claim form transition from the PM-160 form to the CMS-1500 or UB-04 forms or electronic equivalent, per DHCS instruction.
2. The January 1, 2019 CCS transition: language revision to indicate that the current CCS language in the contract shall remain in effect through December 31, 2018; to reference the separate CCS MOU between CalOptima and County that will be effective January 1, 2019; and to reflect that authorized CCS services, with the exception of NICU services, are billable to CalOptima beginning January 1, 2019.
3. Comply with Mega Reg requirements that are applicable to this contract.
4. Update billing and payor information to be consistent with the Medi-Cal Matrix of Financial Responsibility in CalOptima's health network contracts to reflect that County is to bill health networks for members assigned to health networks for:
    a. Adult Immunizations
    b. Pediatric Preventative Services (PPS), including PPS services provided at Orangewood

Fiscal Impact

Management has included expenses associated with the extended contract in the proposed CalOptima FY 2018-19 Operating Budget. The recommended action to execute an amendment to the Coordination and Provision of Public Health Care Services Contract with the County is a budgeted item with no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue CalOptima's contractual relationship with the County, and to comply with DHCS contract requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated May 2, 2013, Consent Calendar VI.A., Authorize the Chief Executive Officer to Execute the "Coordination and Provision of Public Health Care Services Contract" with the Orange County Health Care Agency.
2. Board Action dated September 3, 2015, Report Item VIII.H., Authorize the Chief Executive Officer to Execute an Amendment to Contract with the Orange County Health Care Agency for the Coordination of Targeted Case Management.

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2013
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VI. A. Authorize the Chief Executive Officer to Execute the "Coordination and Provision of Public Health Care Services Contract" with the Orange County Health Care Agency

Contact

Javier Sanchez, Interim Chief Network Officer, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) to execute the "Coordination and Provision of Public Health Care Services Contract" with the Orange County Health Care Agency to replace various existing Memoranda of Understanding.

Background

The Orange County Health Care Agency (HCA) provides various public health programs to Medi-Cal members, as provided under state law, including various clinical services. CalOptima entered into several Memoranda of Understanding (MOUs) between 1996 and 2004 to delineate the roles and responsibilities between CalOptima and HCA as they relate to coordination of care and payment for certain services.

Discussion

While CalOptima and HCA have coordinated operations based on the MOUs over multiple years, DHCS now requires that CalOptima have contracts instead of MOUs in situations in which the other party (i.e., HCA) is a subcontractor to CalOptima. The following eight (8) Medi-Cal MOUs between CalOptima and HCA will be transitioned to the Coordination and Provision of Public Health Care Services Contract:

a. Child Health and Disability Prevention Program (CHDP)
b. California Children's Services (CCS)
c. HIV Programs & HIV Clinic Services
d. Immunization Assistance Project (IAP)
e. Juvenile Health Services-Orangewood (JHS-Orangewood)
f. Maternal, Child & Adolescent Health Program (MCAH)
g. Pulmonary Disease Services (PDS)
h. Sexually Transmitted Diseases Clinical Services

Fiscal Impact

No material fiscal impact is anticipated from the proposed action.

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Rationale for Recommendation
CalOptima staff recommends approval of the proposed action to maintain continued streamlined coordination of delivery of services with HCA consistent with DHCS requirements.

Concurrence
Michael H. Ewing, Chief Financial Officer
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *4/26/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. H. Authorize the Chief Executive Officer to Execute an Amendment to Contract with the Orange County Health Care Agency for the Coordination of Targeted Case Management

Contact
Terrie Stanley, Executive Director Clinical Operations, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend the Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency (OCHCA) to incorporate the coordination of Targeted Case Management (TCM).

Background
On May 2, 2013, the CalOptima Board authorized execution of the "Coordination and Provision of Public Health Care Services Contract" with the OCHCA to replace various existing Memorandums of Understanding (MOU). The effective date of that contract was June 1, 2013.

California's "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver and the related Medi-Cal Managed Care Expansion requires broader responsibility for care coordination and case management services for beneficiaries by Managed Care Plans (MCP), including CalOptima. This includes coordination and referral of resources for client social support issues. In order to implement a collaborative approach regarding TCM services, the Department of Health Care Services (DHCS) is requiring Local Government Agencies (LGAs) in all Medi-Cal Managed Care counties (including the Orange County Health Care Agency) to enter into MOUs or agreements/amendments with the respective managed care plans. To meet these requirements, DHCS's required provisions must be included in CalOptima's current "Coordination and Provision of Public Health Care Services Contract" with the OCHCA. The proposed amendment will serve to define the respective responsibilities and necessary coordination between the two agencies.

Discussion
DHCS has developed protocols for this coordination. Both CalOptima and the OCHCA's TCM programs are required to comply with Health Insurance Portability and Accountability Act (HIPPA) requirements when sharing medical information. Both agencies will pursue obtaining HIPAA authorization from members and/or clients to allow sharing of medical information. To facilitate this coordination, DHCS will provide electronic information identifying CalOptima members receiving TCM within the last three months.

Case management is defined in the Code of Federal Regulations (CFR). While both CalOptima and OCHCA TCM programs provide case management, there is a distinction between the types of services each must provide.

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CalOptima's TCM program primarily focuses on client medical needs in providing case management as the primary provider of client medical care. This may include management of acute or chronic illness. These services include: (1) coordination of care, (2) medical referrals, (3) continuity of care, (4) follow-up on missed appointments, and (5) communication with specialists.

OCHCA TCM program does not manage illness and are not providers of medical services and case management does not include the direct delivery of underlying medical, social, educational, or other services to which an individual has been referred.

CalOptima will partner with OCHCA to ensure that members receive the appropriate level of case management services. Responsibilities include:

- Oversee the delivery of primary health care and related care coordination
- Be responsible for providing all covered health care identified in the care plan including:
  - Medical education that may be needed
  - Any necessary medical referral authorizations
- Handle medical issues as well as medical referrals and linkages to covered health services will be the responsibility
- Provide members with linkage and care coordination for any identified social support needs identified that do not rise to the level of needing care management
- Refer clients to OCHCA TCM for any necessary case management of non-medical needs identified
- Provide health assessments and care plans for all members as needed.

OCHCA TCM Program will:

- Provide TCM services for medical, social, educational, and other services needing case management
- Refer members with open TCM cases to CalOptima for medical needs when identified by the TCM case manager
- Provide TCM Program services to clients who require services which will assist them in gaining access to needed medical, social, educational or other services per Title 42 CFT Section 440-169.

For members needing immediate case manager intervention, the OC HCA TCM case manager provides all necessary assessments, care plans as appropriate, medical or otherwise, to address the member's immediate medical need, apprising CalOptima as soon as possible.

Fiscal Impact

The recommended action to amend the Coordination and Provision of Public Health Care Services Contract with the OCHCA to incorporate the coordination of TCM is budget neutral to CalOptima.

Rationale for Recommendation

The recommendation to amend the Coordination and Provision of Public Health Care Services Contract with the OCHCA to incorporate the coordination of TCM will ensure that CalOptima is compliant with DHCS's requirements for TCM.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

8/28/2015 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
8. Consider Authorizing Extending the OneCare Physician Medical Group Shared Risk Contracts

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend and extend the Physician Medical Group (PMG) contracts with AltaMed Health Services, AMVI/Prospect Medical Group, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Monarch HealthCare, Noble Community Medical Associates and United Care Medical Group OneCare Shared Risk Physician Medical Group (PMG) contracts to: extend these agreements for the period January 1, 2019 through December 31, 2019.

Background and Discussion
CalOptima is required to submit an annual bid to Centers for Medicare & Medicaid services (CMS) for the OneCare program. At the May 2018 meeting, the CalOptima Board of Directors authorized submission of the OneCare bid for calendar year 2019. The bid has been accepted by CMS. Staff now seeks authority to extend contracts through December 31, 2019.

CalOptima contracts with eight PMGs for OneCare. Each of these contracts currently expire on December 31, 2018. Staff is seeking Board authorization to extend these contracts through December 31, 2019.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $5.4 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019, is a budgeted item.

Management will include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network.

Concurrence
Gary Crockett, Chief Counsel

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Attachment
Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader *10/24/2018*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Avenue	Cypress	CA	90630
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

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Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to Provider Health Network Contracts Except Those Pertaining to the CalOptima Community Network Contracts

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO) to enter into contract amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, for AltaMed Health Services, AMVI Care Health Network, CHOC Physicians Network, Children's Hospital of Orange County, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Kaiser Foundation Health Plan, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan and United Care Medical Group to continue to pay individual providers Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities for services rendered in State Fiscal Year (SFY) 2018-19 and for future extensions as long the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

Background/Discussion

The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for SFY 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) were required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19. The proposed SFY 2018-19 extension included new reimbursement rates and eligible procedure codes.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. Proposition 56 provider payments apply to certain Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks: CalOptima Community Network (CCN) and CalOptima Direct (COD), or delegated health networks. On June 7, 2018, the CalOptima Board of Directors approved the methodology for the disbursement of Proposition 56 payments with the understanding that the same process would be utilized should provisions under Proposition 56 be extended past SFY 2017-18. Additionally, on June

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7, 2018, the CalOptima Board of Directors approved health network and physician contract amendments to effectuate Proposition 56 payments.

On September 25, 2018 DHCS verbally instructed Medi-Cal Managed Care Plans to continue paying the established SFY 2017-18 Proposition 56 criteria, rates, and procedure codes for services rendered in SFY 2018-19 until DHCS finalizes the SFY 2018-19 Proposition 56 requirements. On September 26, 2018, DHCS confirmed this guidance in writing. To continue Proposition 56 provider payments, health network contracts need to be amended to extend the dates of service eligible for Proposition 56 payments into SFY 2018-19. CalOptima staff will seek subsequent Board action once SFY 2018-19 Proposition 56 criteria, rates, and procedure codes are finalized and communicated by DHCS.

Fiscal Impact

The recommended action to enter into contract amendments with Medi-Cal health networks to continue Proposition 56 provider payments to eligible providers in SFY 2018-19 and for future periods, if enacted with appropriate funding levels, is expected to be budget neutral to CalOptima. CalOptima received initial funding of $4.26 per member per month (PMPM) for SFY 2017-18 Proposition 56 payments in the monthly capitation payment from DHCS beginning on April 30, 2018. Since then, DHCS has included Proposition 56 funding in subsequent capitation payments.

Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments in SFY 2018-19. However, since Proposition 56 funding will not be subject to a retrospective reconciliation, plans will be at risk for any expenses that exceed revenue. Assuming that actual utilization during the effective period will be similar to historic experience levels, staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation

The recommended action will enable CalOptima to be complaint with Proposition 56 requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

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- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
CHOC Physicians Network	1120 West La Veta Avenue, Suite 450	Orange	CA	92868
Children's Hospital of Orange County	1120 West La Veta Avenue, Suite 450	Orange	CA	92868
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 East Walnut Street, 2nd Floor	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Provider Contracts Except Those Associated with St. Joseph Health and the University of California, Irvine

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 CalOptima Community Network physician contracts, except those associated with St. Joseph Health and the University of California, Irvine (UCI), to continue Proposition 56 payments for eligible services rendered in State Fiscal Year (SFY) 2018-19 and for future extensions as long as the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

Background/Discussion

The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for SFY 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) were required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19. The proposed SFY 2018-19 extension included new reimbursement rates and eligible procedure codes.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. Proposition 56 provider payments apply to certain Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks: CalOptima Community Network (CCN) and CalOptima Direct (COD), or delegated health networks. On June 7, 2018, the CalOptima Board of Directors approved the methodology for the disbursement of Proposition 56 payments with the understanding that the same process would be utilized should provisions under Proposition 56 be extended past SFY 2017-18. Additionally, on June 7, 2018, the CalOptima Board of Directors approved health network and physician contract amendments to effectuate Proposition 56 payments.

On September 25, 2018 DHCS verbally instructed Medi-Cal Managed Care Plans to continue paying the established SFY 2017-18 Proposition 56 criteria, rates, and procedure codes for services rendered

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in SFY 2018-19 until DHCS finalizes the SFY 2018-19 Proposition 56 requirements. On September 26, 2018, DHCS confirmed this guidance in writing. To continue Proposition 56 provider payments, CCN physician contracts, except those associated with St. Joseph Health and the University of California, Irvine, need to be amended to extend the dates of service eligible for Proposition 56 payments into SFY 2018-19. CalOptima staff will seek subsequent Board action once SFY 2018-19 Proposition 56 criteria, rates, and procedure codes are finalized and communicated by DHCS.

Fiscal Impact
The recommended action to enter into contract amendments with CCN physicians to continue Proposition 56 provider payments to eligible providers in SFY 2018-19 and for future periods, if enacted with appropriate funding levels, is expected to be budget neutral to CalOptima. CalOptima received initial funding of $4.26 per member per month (PMPM) for SFY 2017-18 Proposition 56 payments in the monthly capitation payment from DHCS beginning on April 30, 2018. Since then, DHCS has included Proposition 56 funding in subsequent capitation payments.

Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments in SFY 2018-19. However, since Proposition 56 funding will not be subject to a retrospective reconciliation, plans will be at risk for any expenses that exceed revenue. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be complaint with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

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- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Specialist Provider Contracts Associated with St. Joseph Health

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 CalOptima Community Network Specialist physician contracts associated with St. Joseph Health, to continue Proposition 56 payments for eligible services rendered in State Fiscal Year (SFY) 2018-19 and for future extensions as long as the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

Background/Discussion

The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for SFY 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) were required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19. The proposed SFY 2018-19 extension included new reimbursement rates and eligible procedure codes.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. Proposition 56 provider payments apply to certain Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks: CalOptima Community Network (CCN) and CalOptima Direct (COD), or delegated health networks. On June 7, 2018, the CalOptima Board of Directors approved the methodology for the disbursement of Proposition 56 payments with the understanding that the same process would be utilized should provisions under Proposition 56 be extended past SFY 2017-18. Additionally, on June 7, 2018, the CalOptima Board of Directors approved health network and physician contract amendments to effectuate Proposition 56 payments.

On September 25, 2018 DHCS verbally instructed Medi-Cal Managed Care Plans to continue paying the established SFY 2017-18 Proposition 56 criteria, rates, and procedure codes for services rendered in SFY 2018-19 until DHCS finalizes the SFY 2018-19 Proposition 56 requirements. On September

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26, 2018, DHCS confirmed this guidance in writing. To continue Proposition 56 provider payments, CCN specialist physician contracts associated with St. Joseph Health need to be amended to extend the dates of service eligible for Proposition 56 payments into SFY 2018-19. CalOptima staff will seek subsequent Board action once SFY 2018-19 Proposition 56 criteria, rates, and procedure codes are finalized and communicated by DHCS.

Fiscal Impact

The recommended action to enter into contract amendments with CCN physicians to continue Proposition 56 provider payments to eligible providers in SFY 2018-19 and for future periods, if enacted with appropriate funding levels, is expected to be budget neutral to CalOptima. CalOptima received initial funding of $4.26 per member per month (PMPM) for SFY 2017-18 Proposition 56 payments in the monthly capitation payment from DHCS beginning on April 30, 2018. Since then, DHCS has included Proposition 56 funding in subsequent capitation payments.

Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments in SFY 2018-19. However, since Proposition 56 funding will not be subject to a retrospective reconciliation, plans will be at risk for any expenses that exceed revenue. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation

The recommended action will enable CalOptima to be complaint with Proposition 56 requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachment

CalOptima Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

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- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Primary Care Provider Contracts Associated with St. Joseph Health

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 CalOptima Community Network Primary Care Provider contracts associated with St. Joseph Health, to continue Proposition 56 payments for eligible services rendered in State Fiscal Year (SFY) 2018-19, and for future extensions as long as the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

Background/Discussion

The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for SFY 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) were required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19. The proposed SFY 2018-19 extension included new reimbursement rates and eligible procedure codes.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. Proposition 56 provider payments apply to certain Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks: CalOptima Community Network (CCN) and CalOptima Direct (COD), or delegated health networks. On June 7, 2018, the CalOptima Board of Directors approved the methodology for the disbursement of Proposition 56 payments with the understanding that the same process would be utilized should provisions under Proposition 56 be extended past SFY 2017-18. Additionally, on June 7, 2018, the CalOptima Board of Directors approved health network and physician contract amendments to effectuate Proposition 56 payments.

On September 25, 2018, DHCS verbally instructed Medi-Cal Managed Care Plans to continue paying the established SFY 2017-18 Proposition 56 criteria, rates, and procedure codes for services rendered in SFY 2018-19 until DHCS finalizes the SFY 2018-19 Proposition 56 requirements. On September

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26, 2018, DHCS confirmed this guidance in writing. To continue Proposition 56 provider payments, CCN Primary Care Provider contracts associated with St. Joseph Health need to be amended to extend the dates of service eligible for Proposition 56 payments into SFY 2018-19. CalOptima staff will seek subsequent Board action once SFY 2018-19 Proposition 56 criteria, rates, and procedure codes are finalized and communicated by DHCS.

Fiscal Impact

The recommended action to enter into contract amendments with CCN physicians to continue Proposition 56 provider payments to eligible providers in SFY 2018-19 and for future periods, if enacted with appropriate funding levels, is expected to be budget neutral to CalOptima. CalOptima received initial funding of $4.26 per member per month (PMPM) for SFY 2017-18 Proposition 56 payments in the monthly capitation payment from DHCS beginning on April 30, 2018. Since then, DHCS has included Proposition 56 funding in subsequent capitation payments.

Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments in SFY 2018-19. However, since Proposition 56 funding will not be subject to a retrospective reconciliation, plans will be at risk for any expenses that exceed revenue. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation

The recommended action will enable CalOptima to be complaint with Proposition 56 requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachment

CalOptima Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

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99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
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99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

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- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

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- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Mental Health Provider Contracts Associated with St. Joseph Health

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 CalOptima Community Network Mental Health Provider contracts associated with St. Joseph Health, to continue Proposition 56 payments for eligible services rendered in State Fiscal Year (SFY) 2018-19 and for future extensions as long as the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

Background/Discussion

The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for SFY 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) were required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19. The proposed SFY 2018-19 extension included new reimbursement rates and eligible procedure codes.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. Proposition 56 provider payments apply to certain Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks: CalOptima Community Network (CCN) and CalOptima Direct (COD), or delegated health networks. On June 7, 2018, the CalOptima Board of Directors approved the methodology for the disbursement of Proposition 56 payments with the understanding that the same process would be utilized should provisions under Proposition 56 be extended past SFY 2017-18. Additionally, on June 7, 2018, the CalOptima Board of Directors approved health network and physician contract amendments to effectuate Proposition 56 payments.

On September 25, 2018 DHCS verbally instructed Medi-Cal Managed Care Plans to continue paying the established SFY 2017-18 Proposition 56 criteria, rates, and procedure codes for services rendered in SFY 2018-19 until DHCS finalizes the SFY 2018-19 Proposition 56 requirements. On September

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26, 2018, DHCS confirmed this guidance in writing. To continue Proposition 56 provider payments, CCN Mental Health Provider contracts associated with St. Joseph Health need to be amended to extend the dates of service eligible for Proposition 56 payments into SFY 2018-19. CalOptima staff will seek subsequent Board action once SFY 2018-19 Proposition 56 criteria, rates, and procedure codes are finalized and communicated by DHCS.

Fiscal Impact

The recommended action to enter into contract amendments with CCN physicians to continue Proposition 56 provider payments to eligible providers in SFY 2018-19 and for future periods, if enacted with appropriate funding levels, is expected to be budget neutral to CalOptima. CalOptima received initial funding of $4.26 per member per month (PMPM) for SFY 2017-18 Proposition 56 payments in the monthly capitation payment from DHCS beginning on April 30, 2018. Since then, DHCS has included Proposition 56 funding in subsequent capitation payments.

Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments in SFY 2018-19. However, since Proposition 56 funding will not be subject to a retrospective reconciliation, plans will be at risk for any expenses that exceed revenue. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation

The recommended action will enable CalOptima to be complaint with Proposition 56 requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
2. Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

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- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
St. Jude Neighborhood Health Centers	731 S. Highland Avenue	Fullerton	CA	92832

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Provider Contracts Associated with the University of California, Irvine

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 CalOptima Community Network provider contracts associated with the University of California, Irvine (UCI) to continue Proposition 56 payments for eligible services rendered in State Fiscal Year (SFY) 2018-19, and for future extensions as long as the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

Background/Discussion

The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for SFY 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) were required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19. The proposed SFY 2018-19 extension included new reimbursement rates and eligible procedure codes.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. Proposition 56 provider payments apply to certain Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks: CalOptima Community Network (CCN) and CalOptima Direct (COD), or delegated health networks. On June 7, 2018, the CalOptima Board of Directors approved the methodology for the disbursement of Proposition 56 payments with the understanding that the same process would be utilized should provisions under Proposition 56 be extended past SFY 2017-18. Additionally, on June 7, 2018, the CalOptima Board of Directors approved health network and physician contract amendments to effectuate Proposition 56 payments.

On September 25, 2018 DHCS verbally instructed Medi-Cal Managed Care Plans to continue paying the established SFY 2017-18 Proposition 56 criteria, rates, and procedure codes for services rendered in SFY 2018-19 until DHCS finalizes the SFY 2018-19 Proposition 56 requirements. On September

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26, 2018, DHCS confirmed this guidance in writing. To continue Proposition 56 provider payments, CCN provider contracts associated with UCI need to be amended to extend the dates of service eligible for Proposition 56 payments into SFY 2018-19. CalOptima staff will seek subsequent Board action once SFY 2018-19 Proposition 56 criteria, rates, and procedure codes are finalized and communicated by DHCS.

Fiscal Impact

The recommended action to enter into contract amendments with CCN physicians to continue Proposition 56 provider payments to eligible providers in SFY 2018-19 and for future periods, if enacted with appropriate funding levels, is expected to be budget neutral to CalOptima. CalOptima received initial funding of $4.26 per member per month (PMPM) for SFY 2017-18 Proposition 56 payments in the monthly capitation payment from DHCS beginning on April 30, 2018. Since then, DHCS has included Proposition 56 funding in subsequent capitation payments.

Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments in SFY 2018-19. However, since Proposition 56 funding will not be subject to a retrospective reconciliation, plans will be at risk for any expenses that exceed revenue. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation

The recommended action will enable CalOptima to be complaint with Proposition 56 requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachment

CalOptima Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

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- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2018-19 Capital Budget for the CalOptima Provider Portal Project

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400

Recommended Action

Authorize reallocation of budgeted but unused funds of $675,000 from Capital Hardware and Software to Capital Professional Fees to fund the CalOptima Provider Portal project through June 30, 2019.

Background

In March 2011, CalOptima contracted with a vendor that provides the current provider portal solution, branded as "CalOptima Link." The current portal has limited functionality and annual licensing and maintenance fees of just over $1.5 million per year. Of the existing functions, such as eligibility verification, submission of authorization requests, provider claim status, and provider roster, the most frequently used by the provider community is eligibility verification.

A project to implement a new and more feature-rich portal has been on the project roadmap since 2013, however, other more business critical projects have taken priority until now. In 2017, Staff formed a workgroup of Care Management and Operations Staff to define business requirements for an improved portal solution.

The project was officially proposed for the CalOptima Fiscal Year (FY) 2018-19 Capital Budget and was ultimately approved at the Board meeting of June 7, 2018. The project was defined to deliver a new provider portal solution - either a vendor-provided solution or an in-house custom developed solution.

Research was completed by Information Services Staff to determine the availability of commercially available solutions that could be purchased to satisfy CalOptima's business requirements. The research consisted of (a) surveying the other Medi-Cal Health Plans to learn about their provider portal solutions; (b) attendance at presentations conducted by some portal vendors in use by the other Medi-Cal plans at the monthly Chief Information Officer meetings with those Plans; and (c) consulting the CalOptima-contracted technology research vendor, Gartner, for information regarding trends in the industry, pros and cons of many vendor solutions, and specific intelligence about how other Med-Cal and Commercial Health Plans are implementing portal solutions across the United States.

It became clear that no commercially available solution would satisfy all the defined CalOptima business requirements with reasonable costs for licensing, maintenance, and custom development/enhancements. An internally developed solution will incur lower recurring costs and will operate on primarily existing hardware and use primarily existing software development tools.

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Additionally, internal software development work for the CalOptima Member Portal and the CalOptima.org public website is already completed (yet ongoing) and economies of scale for common features can be realized. Therefore, the decision was made to implement an in-house custom developed solution.

As a result, staff is recommending that the Board authorize that funding from the approved FY 2018-19 hardware and software capital budget be shifted to professional fees.

Discussion
The CalOptima FY 2018-19 Capital Budget was approved by the CalOptima Board of Directors on June 7, 2018. The budget for the provider portal solution included hardware expenses of $50,000, software expenses of $700,000, and professional fees expenses of $300,000, totaling $1,050,000.

To complete this software development work internally, the expenses require shifting. Management proposes to make a reallocation of budgeted funds of $675,000, to reflect that less hardware and software will be needed. Specifically, Management recommends:

- Reallocation of $25,000 from Capital Hardware to Capital Professional Fees; and
- Reallocation of $650,000 from Capital Software to Capital Professional Fees.

The reallocation to Capital Professional Fees will provide funding for additional temporary labor to develop the software for the provider portal solution internally. While additional resources will be necessary for some of the design, development, testing and quality assurance of the new software, it is not anticipated that these resources will be required long term, rather only for a portion of Calendar Year 2019. At this time, staff has estimated three to four temporary resources at approximately $90.00 to $150.00 per hour, depending on skillset. The total expenses for the project will remain unchanged at $1,050,000, with no additional funds requested.

Fiscal Impact
The fiscal impact for this recommended action is budget neutral.

Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Ratifying a Revised Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS)

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Silver Ho, Executive Director of Compliance, (714) 246-8400

Recommended Action
Ratify revised Amendment 33 of the Primary Agreement between CalOptima and DHCS.

Background
As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion
On September 27, 2018, the DHCS sent CalOptima a revised version of Amendment 33 (A–33) to the Primary Agreement with the DHCS. In that communication, DHCS requested that CalOptima sign and return the revised amendment as soon as possible, and no later than October 12, 2018.

The original version of the amendment was signed by the Chair of the CalOptima Board of Directors (Board) on November 2, 2017, pursuant to authority granted to him during the February 2017 meeting of the Board. The original version of the amendment established base capitation rates for July 2016 to June 2017, as well as supplemental rates related to Behavioral Health Treatment (BHT) and Hepatitis C treatment.

The revised amendment includes language changes related to the Adult Expansion (AE) Medical Loss Ratio (MLR). Specifically, the revised amendment retroactively extends the existing AE MLR requirements by one year, by adding a third period from July 1, 2016 to June 30, 2017. The amendment also provides that DHCS will initiate the AE MLR calculation no sooner than January 1, 2019, for the third period. All other AE MLR requirements and related provisions are unchanged.

As previously noted, DHCS requested that CalOptima sign and return the revised amendment as soon as possible, and no later than October 12, 2018. In order to meet DHCS's deadline, CalOptima staff procured the Chair's signature on October 4, 2018 and returned the signed Amendment A–33 to DHCS the next day. Staff requests the CalOptima Board of Directors' ratification of the Board Chair's execution of the revised Amendment A–33 to the Primary Agreement with DHCS.

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Fiscal Impact
The recommended action to ratify the revised A-33 of the Primary Agreement with DHCS is expected to be budget neutral to CalOptima. The AE MLR risk corridor establishes a threshold of 85%, which is below CalOptima's AE MLR during Fiscal Year (FY) 2016-17. As such, CalOptima does not anticipate that DHCS will recoup funding related to the AE MLR requirements for the third period of July 1, 2016, through June 30, 2017.

Rationale for Recommendation
DHCS has indicated that the additional year of AE MLR requirements is a priority of the Centers for Medicare and Medicaid Services (CMS). DHCS has informed Plans that CMS indicated that the additional AE MLR period is a necessary prerequisite for CMS's approval of the FY 2016–17 rates developed by DHCS, and which DHCS has provided to Plans. CalOptima has used those rates for budgetary planning purposes.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to Primary and Secondary Agreements with DHCS

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 17

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017

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)

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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

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

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Authorizing and Directing Execution of Amendments to Extend the Agreement with the California Department of Health Care Services (DHCS) for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

Emily Fonda, M.D., Interim Chief Medical Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute Amendment A06 to the PACE Agreement between DHCS and CalOptima to extend the agreement through December 31, 2019.

Background

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

The CalOptima DHCS PACE Agreement specifies, among other terms and conditions, the capitation payment rates CalOptima receives from DHCS to provide health care services. The current Agreement expires on December 31, 2018, while the capitation rates are meant to be renewed on a calendar year basis.

Discussion

On September 25, 2018, DHCS provided CalOptima with a draft Amendment A06 for the DHCS PACE Agreement to include updates for:

- Extending the contract termination date to December 31, 2019.
- Increasing the maximum amount payable to accommodate the additional year of the contract.
- All other terms and conditions in the CalOptima DHCS PACE Agreement remain the same.

DHCS submitted this Amendment in mid-August for CMS review and approval. Upon CMS approval, DHCS will provide PACE plans with a final Amendment for execution. CalOptima staff anticipates that the final Amendment will be consistent with the draft materials presented to-date. If they are materially different than anticipated, CalOptima staff will return to the Board with further recommendations.

Fiscal Impact

Management has incorporated the draft CY 2018 and forecasted CY 2019 PACE capitation rates in the CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018. The

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recommended action to execute Amendment A06 to the DHCS PACE Agreement on extending the contract termination date to December 31, 2019, under the same terms and conditions of the current agreement is a budgeted item with no additional fiscal impact.

Rationale for Recommendation
CalOptima's execution of Amendment A06 to the DHCS PACE Agreement is necessary for the continued operation of CalOptima PACE.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to PACE Primary Agreements

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 18

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

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

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Amendments to Primary Agreement with DHCS	Board Approval
Future Amendment (A05) provided draft capitation rates for CY 2017 for the period of January 1, 2017 through December 31, 2017, developed by the "Amount That Would Have Otherwise Been Paid (AWOP)", and apply the Managed Care Organization (MCO) Tax for the period January 1, 2017 through June 30, 2017.	December 7, 2017
A06 provided an extension of the contract termination date to December 31, 2019.	**Pending**
Amendments to Primary Agreement with CMS	**Board Approval**
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016
A02 CalOptima PACE initiated a waiver to allow Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in CalOptima PACE, which was approved by CMS on March 12, 2018 and amended *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	September 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Consider Authorizing Exploration of CalOptima's Participation in Be Well Orange County

Contact
Michael Schrader, Chief Executive Officer, (714) 246-8400
Edwin Poon, Director, Behavioral Health Services, (714) 246-8400
Cheryl Meronk, Director, Strategic Development, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer:
1. To participate in the Be Well Orange County initiative by facilitating discussions regarding one or more of the proposed result areas; and
2. To assess the feasibility of CalOptima's participation with the Orange County Health Care Agency (OCHCA) and various hospital systems in support of the Be Well Orange County Initiative.

Background
In March 2017, CalOptima was invited to attend a meeting hosted by Providence St. Joseph Health to address the mental health care system in Orange County. Other participants included government representatives, hospital systems, OCHCA, faith-based organizations, the National Alliance of Mental Illness – Orange County (NAMI–OC) and other community stakeholders. The availability of behavioral health resources in Orange County and how to navigate the system of care were discussed. The conversation led to the creation of the Orange County Coalition for Behavioral Health (Coalition). In addition, three workgroups were established to address funding, site development (i.e., infrastructure) and system of care issues. After the initial gathering, CalOptima staff continued to attend the bimonthly Coalition meeting to provide input and receive updates from the workgroups.

In 2017, the Coalition created a not-for-profit, public charity called Mind OC. The role of Mind OC is to promote, facilitate and support existing mental health services and to fill gaps in care that exist across the county. After the formation of Mind OC, the organization began to explore financial resources to support the goal of creating a high-quality behavioral health system of care for all county residents. Coalition leaders also assisted the county in the search for locations to create a center for mental health and substance use disorder treatment services and expand the number of Crisis Stabilization Units.

In March 2018, the Regional Executive Director of the Institute for Mental Health and Wellness at Providence St. Joseph Health attended CalOptima's special joint meeting of the Member Advisory, OneCare Connect Member Advisory and Provider Advisory Committees. He made a presentation about the mission and work of the Coalition.
In June 2018, the Coalition announced it formally adopted the name Be Well OC with the following mission statement: "Orange County will lead the nation in optimal mental health and wellness for all

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residents." In addition, a blueprint was created with the support of a variety of public and private stakeholders across the county to articulate the steps needed to actualize the Be Well OC vision. The blueprint describes the system of care issues, barriers and solutions, with six pillars for action:

1. Systems Change
2. Responsive and Inclusive
3. Aligned and Accountable
4. Integrative and Future-Focused
5. Evidence-Based and Quality-Driven Care
6. Fueled by a Mind OC Wellness Fund

Discussion

A two-day summit was held at the Saddleback Church in San Jan Capistrano on August 9–10 to provide additional information about the proposed Be Well OC Blueprint. The goals of the summit were to identify results/leadership organizations, identify metrics to track improvements in each result, and establish a communication plan and timeline for future activities. CalOptima CEO, Michael Schrader and Behavioral Health Services Director Edwin Poon, attended the event. During the summit, attendees were asked to identify organizations to collectively impact the outcomes of six result areas:

1. Reduce stigma
2. Prevent and act early
3. Close treatment gaps and improve access
4. Strengthen crisis response
5. Establish community wellness hubs
6. Align partners, policies and programs

CalOptima, with its focus and funding available to serve the Orange County Medi-Cal population, was nominated by the attendees to be one of the organizations to take the lead in facilitating the work associated with achieving these result areas. Other identified organizations included OCHCA, CHOC Children's, Saddleback Church, NAMI–OC, Orange County Department of Education, University of California, Irvine (UCI), Orange County United Way, and Multi-Ethnic Collaborative of Community Agencies (MECCA). A follow-up brainstorming session was held in September 2018 to help identify organizations to facilitate the result areas and finalize the list of impact organizations. At the meeting, with a focus on the Medi-Cal population, CalOptima staff tentatively agreed to participate in result areas #3 (Closing treatment gaps) and #5 (establish community wellness hubs).

As a foundational component of the Be Well blueprint, three regional Wellness Hubs are envisioned to be developed to support the proposed countywide mental health system of care. Depending on the specific needs of the service planning area in which each Wellness Hub is located, these Wellness Hubs will be intended to provide services to individuals in need to address a range of mental health levels of risk and complexity and will also provide necessary linkages to complimentary community and social services.

The first of the three regional Wellness Hubs is being planned for development in the City of Orange, to be located on property purchased by the County of Orange on behalf of OCHCA at 265 Anita Drive. The Wellness Hub proposal is intended to leverage public-private collaboration to develop a new

60,000-square-foot building to house seven service elements that will comprise the first Be Well Regional Hub. These services would be available to all adolescents and adults in the area (regardless of insurance coverage) and will include triage, psychiatric intake and referral, substance use disorder intake and referral, withdrawal management, transitional residential services, residential treatment services, and an integrated support center providing community and faith-based services in support of the above programming.

The initial development cost for this first Wellness Hub are estimated at $34.2 million. And while the Be Well leadership team has proposed that CalOptima provide investment in the project equaling one-third of the initial project costs, at this time, staff is requesting authority to facilitate further discussions regarding the proposed Be Well results areas, and studying the feasibility of CalOptima's participation (including reviewing potential financial support if and as permitted by CalOptima's enabling statute and other applicable laws) along with various community partners for the benefit of CalOptima members. Additional information and analysis will be brought to your Board at a future meeting for further discussion.

Fiscal Impact
There is no fiscal impact to the recommended action to perform a feasibility analysis on CalOptima's participation in the Be Well Orange County Initiative. Existing Staff will conduct the feasibility analysis, with no additional fiscal impact.

Rationale for Recommendation
In collaboration with community partners, staff recommends that the board authorize facilitation of continuing discussions regarding the Be Well Initiative and looking into the feasibility of CalOptima's participation.

Concurrence
Gary Crockett, Chief Counsel

Attachments
PowerPoint Presentation: Be Well OC Activities

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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Be Well OC Activities

Board of Directors Meeting

November 1, 2018

Edwin Poon, Ph.D., Director, Behavioral Health Services

Cheryl Meronk, Director, Strategic Development

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OC Coalition for Behavioral Health

- In March 2017, St. Joseph Health invited CalOptima and other stakeholders to discuss improvements to the mental health care system in Orange County
  - Orange County Health Care Agency
  - Government representatives
  - Faith-based organizations
  - National Alliance of Mental Illness – Orange County
  - Hospital systems
  - Community stakeholders
- This group became known as the Orange County Coalition for Behavioral Health
- Three workgroups were established to address system of care, infrastructure and funding

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Coalition 2017 Accomplishments

- Established Mind OC, a not-for-profit public charity corporation to promote, facilitate and support existing mental health services and fill gaps in care
- Assisted the County in the search for a site for comprehensive mental health and substance use disorder treatment services
- Worked on identifying potential sites for Crisis Stabilization Units
- Established relationships with other agencies and organizations with similar directions and goals
- Developed Mind OC Continuum of Care

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Mind OC Continuum of Care

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Be Well OC

- In June 2018, the Coalition announced Be Well OC as its official name and created a mission statement
  - "Orange County will lead the nation in optimal mental health and wellness for all residents."

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Be Well OC Blueprint

- Be Well OC created a blueprint to determine the steps needed to fulfill the mission
- The blueprint outlines the challenges, solutions, pillars for action, collective impact and result areas

Pillars For Actions
1. System change
2. Responsive and inclusive
3. Aligned and accountable
4. Integrative and future-focused
5. Evidence-based and quality-driven care
6. Fueled by Mind OC Wellness Fund

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Blueprint — Leadership Structure

Distributed Leadership Structure

System of Care Backbone: Frames the work of the full, collaborative portfolio

Result Backbone: Organization(s) dedicated to facilitating the work associated with achieving this result

Impact Organizations: Implementing interventions related to the result

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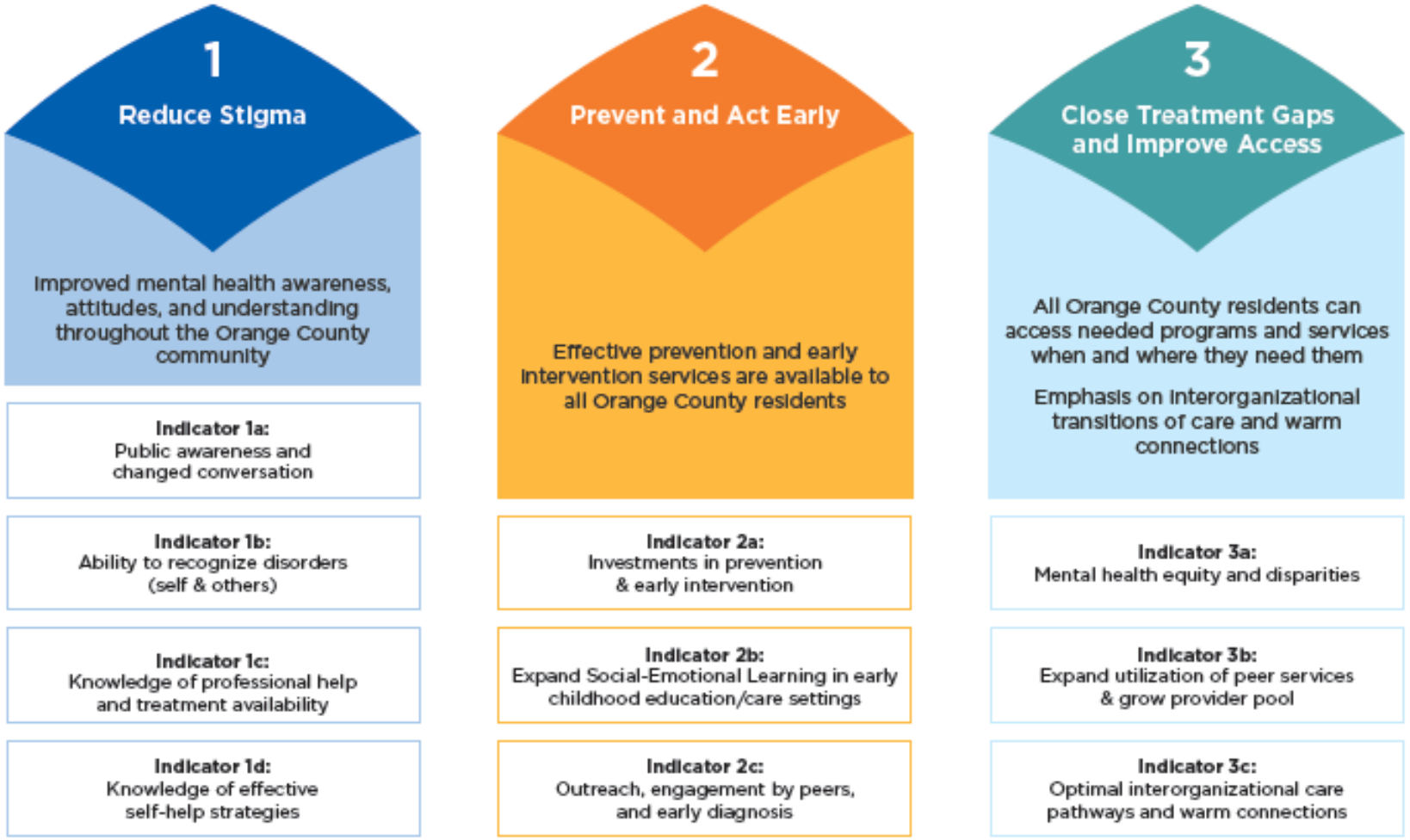
CalOptima A Public Agency Better. Together.

Blueprint — Result Areas



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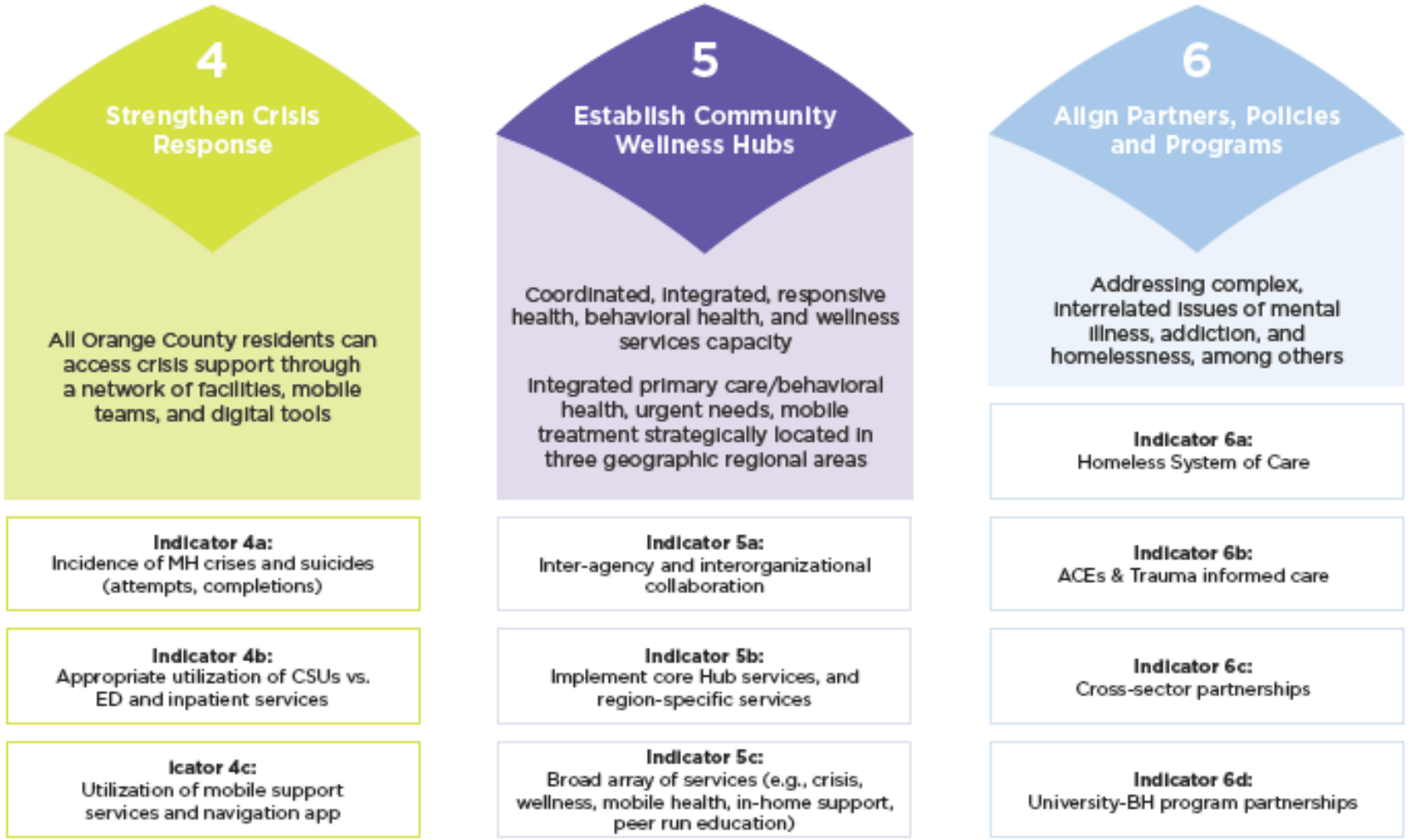
CalOptima
A Public Agency
Better. Together.

Blueprint — Result Areas (Cont.)



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Be Well OC Summit

- A two-day summit was held August 9–10
- Summit goals:
  - Identify results/leadership organizations
  - Identify metrics to track improvements in each result
  - Establish a communication plan and timeline for future activities
- Attendees were asked to identify organizations to collectively impact the outcomes of the result areas
- CalOptima was one of the organizations that attendees recommended take the lead in facilitating the implementation of two result areas
  - #3 Closing treatment gaps and improve access
  - #5 Establish community wellness hubs

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Anita Project

Board of Directors Meeting
November 1, 2018

Cheryl Meronk
Director, Strategic Development

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Community Wellness Hubs

- Be Well OC Blueprint incorporates three regional Wellness Hubs
- Services available at each Wellness Hub will include:
  - Variety of mental health services
  - Substance Use Disorder treatment programs
  - Integrated support services linking community and social services
- Services available to any OC resident
  - Access based on clinical need

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Wellness Hub Services

- Triage
- Psychiatric intake and referral
- Substance use disorder intake and referral
- Withdrawal management
- Transitional residential services
- Residential treatment services
- Integrated support services center
  - Mobile crisis response team
  - Transportation
  - Social and community-based services
  - Faith-based organizations
  - Education, employment and legal services

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Anita St. Wellness Hub

- OCHCA 2016 Strategic Financial Plan includes a priority to develop an integrated behavioral health services campus
  - 44,600-square-foot building purchased at 265 Anita St. in Orange
- Planning for the facility evolved in parallel with Be Well OC Blueprint
  - 60,000-square-foot new construction planned in partnership with Be Well
- Estimated project cost: $34.2 million

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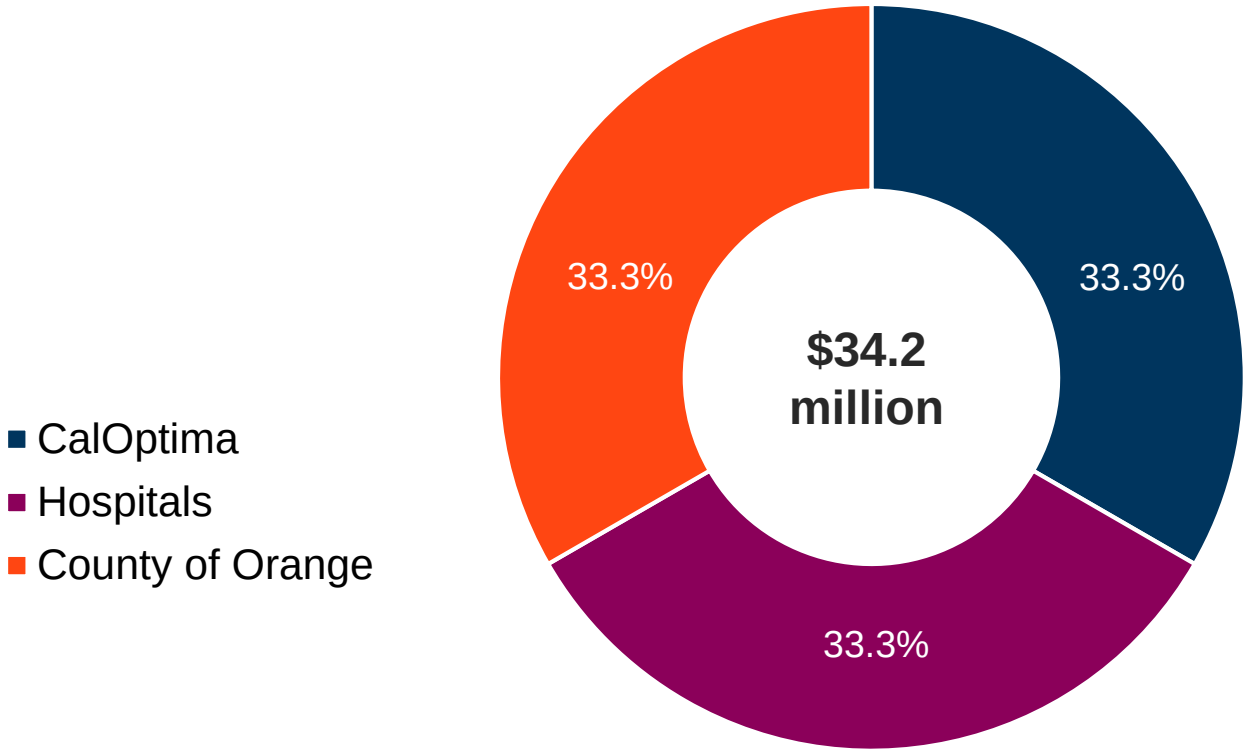
Proposed Financing Model

- Public-private partnership to improve access, experience and outcomes, and reduce costs



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Recommended Actions

Authorize the Chief Executive Officer:

1. To participate in the Be Well Orange County initiative by facilitating discussions regarding one or more of the proposed result areas; and
2. To assess the feasibility of CalOptima's participation with the Orange County Health Care Agency (OCHCA) and various hospital systems in support of the Be Well Orange County Initiative

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
20. Consider Adoption of Resolution to Amend CalOptima's Conflict of Interest Code

Contact
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions
1. Adopt Resolution adopting a Conflict of Interest Code ("Code") which supersedes all prior Conflict of Interest Codes and Amendments previously adopted; and
2. Upon adoption, direct the Clerk of the Board to submit the Code to the Orange County Board of Supervisors for review and approval.

Background
The Fair Political Practices Commission (FPPC) adopted a regulation, Title 2, California Code of Regulations, Section 18730, which contains terms for a standard Model Conflict of Interest Code ("Model Code") that, together with amendments thereto, may be adopted by local public agencies and incorporated by reference. The CalOptima Board of Directors adopted the Model Code by reference on January 6, 2011 and amended Exhibit A to CalOptima's Conflict of Interest Code on December 1, 2016.

When designated positions or reporting categories are added or changed, local agencies are required under Government Code section 87306 to make changes to the conflict of interest code to reflect these changed circumstances. On October 4, 2018, the CalOptima Board of Directors adopted a new Salary Schedule with an updated list of CalOptima employee positions and job titles. The proposed amendment to the list of Designated Filer Positions and Disclosure Categories (Exhibit A) reflects positions that make or participate in the making of governmental decisions which may foreseeably have a material financial effect on a financial interest. All individuals in designated positions will still be required to complete CalOptima's Supplement to FPPC Form 700. Changes have been proposed that update certain positions that have been added, deleted, or renamed.

In addition, the General Counsel for the California Fair Political Practices Commission (FPPC) issued several memorandums opining that "conflict of interest code disclosure categories must be narrowly tailored to the type of economic interests that will foreseeably be affected by a designated employee's decision making." (May 7, 2012, Memorandum from Zackery P. Morazzini, General Counsel of FPPC). Furthermore, in 2012, the FPPC adopted Title 2, California Code of Regulations, Section 18730.1, providing that designated positions are not required to report gifts outside an agency's jurisdiction if the purpose of disclosure of the source of the gift does not have some connection with or bearing upon the functions or duties of the position for which the reporting is required. Additional changes are also proposed to CalOptima's Conflict of Interest Code to

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ensure that disclosure requirements for each position is narrowly tailored to the type of economic interests that will foreseeably be materially affected by a designated employee's decision making.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Adoption of Resolution to adopt CalOptima's Conflict of Interest Code which supersedes all prior Conflict of Interest Codes and Amendments previously adopted is necessary to reflect updates to certain positions that have been added, deleted, or renamed. Disclosure categories have been updated to conform with the County of Orange Standard Disclosure Categories and to tailor the disclosure requirements to the type of economic interests that will foreseeably be affected by each position.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution 18-1101, Adopt Exhibit A and B to the Conflict of Interest Code for the Orange County Health Authority, dba CalOptima
2. Draft Conflict of Interest Code – Exhibits A and B

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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RESOLUTION NUMBER 18-1101

RESOLUTION OF THE BOARD OF DIRECTORS
OF ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

ADOPTING A CONFLICT OF INTEREST CODE
WHICH SUPERSEDES ALL PRIOR CONFLICT OF INTEREST CODES AND
AMENDMENTS PREVIOUSLY ADOPTED

WHEREAS, the Political Reform Act of 1974, Government Code Section 81000 et seq. ("the Act"), requires a local government agency to adopt a Conflict of Interest Code pursuant to the Act and conduct a biennial review of Designated Positions and Disclosure Categories; and

WHEREAS, the Orange County Health Authority, dba CalOptima, has previously adopted a Conflict of Interest Code and that Code now requires updating; and,

WHEREAS, amendments to the Act have in the past and foreseeably will in the future require conforming amendments to be made to the Conflict of Interest Code; and

WHEREAS, the Fair Political Practices Commission has adopted a regulation, Title 2, California Code of Regulations, Section 18730, which contains terms for a standard model Conflict of Interest Code, which, together with amendments thereto, may be adopted by public agencies and incorporated by reference to save public agencies time and money by minimizing the actions required of such agencies to keep their codes in conformity with the Political Reform Act.

NOW THEREFORE, BE IT RESOLVED:

Section 1. The terms of Title 2, California Code of Regulations, Section 18730, and any amendments to it duly adopted by the Fair Political Practices Commission, and all additional guidance by the Fair Political Practices Commission, are hereby incorporated by reference, and together, with the attached Exhibits A and B in which members and employees are designated and disclosure categories are set forth, constitute the Conflict of Interest Code of the Orange County Health Authority, dba CalOptima.

Section 2. The provisions of all Conflict of Interest Codes and Amendments thereto previously adopted by the Orange County Health Authority, dba CalOptima are hereby superseded.

Section 3. The CalOptima Clerk of the Board is hereby authorized and directed to forward a copy of this Resolution to the Clerk of the Orange County Board of Supervisors for review and approval by the Orange County Board of Supervisors as required by California Government Code Section 87303.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima, this 1st day of November 2018.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors

Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Associate Director Provider Network	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Associate Director, Customer Service	OC-41	COB	Unchanged
Associate Director, Human Resources	OC-11	COB	Deleted
Reason: Deleting position since it no longer exists in CalOptima.			
Associate Director, Information Services	OC-08	COB	Unchanged
Buyer	OC-01	COB	Unchanged
Buyer, Int.	OC-01	COB	Unchanged
Buyer, Sr.	OC-01	COB	Unchanged
Chief Counsel	OC-01	COB	Unchanged
Chief Information Officer	OC-01	COB	Unchanged
Chief Medical Officer	OC-01	COB	Unchanged
Chief Operating Officer	OC-01	COB	Unchanged
Clerk of the Board	OC-06	COB	Unchanged
Clinical Pharmacist	OC-20	COB	Unchanged
Consultant	OC-30	Agency	Unchanged
Contract Administrator	OC-06	COB	Unchanged
Contracts Manager	OC-06	COB	Unchanged
Contracts Specialist	OC-06	COB	Unchanged
Contracts Specialist Int.	OC-06	COB	Unchanged
Contracts Specialist Sr.	OC-06	COB	Unchanged
Controller	OC-01	COB	Unchanged
Deputy Chief Counsel	OC-01	COB	Unchanged
Deputy Chief Medical Officer	OC-01	COB	Unchanged
Director, Accounting	OC-01	COB	Unchanged
Director, Applications Management	OC-08	COB	Unchanged
Director, Audit and Oversight	OC-01	COB	Unchanged
Director, Behavioral Health Services	OC-41	COB	Unchanged
Director, Budget & Procurement	OC-01	COB	Unchanged
Director, Business Development	OC-41	COB	Unchanged
Director, Business Integration	OC-41	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Director, Case Management	OC-41	COB	Unchanged
Director, Claims Administration	OC-41	COB	Unchanged
Director, Clinical Outcomes	OC-01	COB	Unchanged
Director, Clinical Pharmacy	OC-01	COB	Unchanged
Director, Coding Initiatives	OC-06	COB	Unchanged
Director, Communications	OC-13	COB	Unchanged
Director, Community Relations	OC-41	COB	Unchanged
Director, Configuration & Coding	OC-06	COB	Unchanged
Director, Contracting	OC-01	COB	Unchanged
Director, COREC	OC-08	COB	Unchanged
Director, Customer Service	OC-41	COB	Unchanged
Director, Electronic Business	OC-06	COB	Unchanged
Director, Enterprise Analytics	OC-06	COB	Unchanged
Director, Facilities	OC-41	COB	Unchanged
Director, Finance & Procurement	OC-01	COB	Unchanged
Director, Financial Analysis	OC-01	COB	Unchanged
Director, Financial Compliance	OC-01	COB	Unchanged
Director, Fraud, Waste & Abuse and Privacy	OC-01	COB	Unchanged
Director, Government Affairs	OC-41	COB	Unchanged
Director, Grievance & Appeals	OC-41	COB	Unchanged
Director, Health Education & Disease Management	OC-41	COB	Unchanged
Director, Health Services	OC-41	COB	Unchanged
Director, Human Resources	OC-11	COB	Unchanged
Director, Information Services	OC-08	COB	Unchanged
Director, Long Term Support Services	OC-41	COB	Unchanged
Director, Medi-Cal Plan Operations	OC-41	COB	Unchanged
Director, Network Management	OC-41	COB	Unchanged
Director, OneCare Operations	OC-41	COB	Unchanged
Director, Organizational Training & Education	OC-11	COB	Unchanged
Director, PACE Program	OC-41	COB	Unchanged
Director, Process Excellence	OC-41	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Director, Program Implementation	OC-41	COB	Unchanged
Director, Project Management	OC-41	COB	Unchanged
Director, Provider Data Quality	OC-41	COB	Unchanged
Director, Provider Services	OC-41	COB	Unchanged
Director, Public Policy	OC-41	COB	Unchanged
Director, Quality (LTSS)	OC-41	COB	Unchanged
Director, Quality Analytics	OC-06	COB	Unchanged
Director, Quality Improvement	OC-41	COB	Unchanged
Director, Regulatory Affairs and Compliance	OC-01	COB	Unchanged
Director, Strategic Development	OC-41	COB	Unchanged
Director, Systems Development	OC-08	COB	Unchanged
Director, Utilization Management	OC-41	COB	Unchanged
Director, Vendor Management	OC-01	COB	Deleted
Reason: Deleting position since it no longer exists in CalOptima.			
Enterprise Analytics Manager	OC-06	COB	Unchanged
Executive Director, Behavioral Health Integration	OC-41	COB	Unchanged
Executive Director, Clinical Operations	OC-01	COB	Unchanged
Executive Director, Compliance	OC-01	COB	Unchanged
Executive Director, Human Resources	OC-01	COB	Unchanged
Executive Director, Network Operations	OC-01	COB	Unchanged
Executive Director, Operations	OC-01	COB	Unchanged
Executive Director, Program Implementation	OC-01	COB	Unchanged
Executive Director, Public Affairs	OC-01	COB	Unchanged
Executive Director, Quality Analytics	OC-06	COB	Unchanged
Financial Analyst	OC-01	COB	Unchanged
Financial Analyst, Sr.	OC-01	COB	Unchanged
Financial Reporting Analyst	OC-01	COB	Unchanged
General Counsel	OC-01	COB	Deleted
Reason: Deleting position since it no longer exists in CalOptima.			
Litigation Support Specialist	OC-41	COB	Unchanged
Manager Systems Development	OC-08	COB	Added

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Accounting	OC-01	COB	Unchanged
Manager, Actuary	OC-01	COB	Unchanged
Manager, Applications Management	OC-08	COB	Unchanged
Manager, Audit and Oversight	OC-01	COB	Unchanged
Manager, Behavioral Health	OC-41	COB	Category Changed
Reason: Alignment with Managers levels			
Manager, Business Integration	OC-06	COB	Unchanged
Manager, Case Management	OC-41	COB	Unchanged
Manager, Claims	OC-41	COB	Unchanged
Manager, Clinic Operations	OC-06	COB	Unchanged
Manager, Clinical Pharmacists	OC-20	COB	Unchanged
Manager, Coding Quality	OC-06	COB	Unchanged
Manager, Communications	OC-13	COB	Unchanged
Manager, Community Relations	OC-06	COB	Unchanged
Manager, Contracting	OC-41	COB	Unchanged
Manager, Creative Branding	OC-13	COB	Unchanged
Manager, Cultural & Linguistics	OC-06	COB	Unchanged
Manager, Customer Service	OC-41	COB	Unchanged
Manager, Decision Support	OC-06	COB	Unchanged
Manager, Disease Management	OC-41	COB	Unchanged
Manager, Electronic Business	OC-06	COB	Unchanged
Manager, Employment Services	OC-11	COB	Unchanged
Manager, Encounters	OC-06	COB	Unchanged
Manager, Environmental Health & Safety	OC-06	COB	Unchanged
Manager, Facilities	OC-41	COB	Unchanged
Manager, Finance	OC-01	COB	Unchanged
Manager, Financial Analysis	OC-01	COB	Unchanged
Manager, Government Affairs	OC-41	COB	Unchanged
Manager, Grievance and Appeals	OC-41	COB	Unchanged
Manager, Health Education	OC-41	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: Other misc authorities, districts and commissions

Agency: CalOptima

Position	Disclosure Category	Files With	Status
Manager, HEDIS	OC-06	COB	Unchanged
Manager, Human Resources	OC-11	COB	Unchanged
Manager, Information Services	OC-08	COB	Unchanged
Manager, Information Technology	OC-08	COB	Unchanged
Manager, Integration Government Liaison	OC-41	COB	Unchanged
Manager, Long Term Support Services	OC-41	COB	Unchanged
Manager, Marketing and Enrollment	OC-06	COB	Unchanged
Manager, Medical Data Management	OC-06	COB	Unchanged
Manager, Medi-Cal Program Operations	OC-41	COB	Unchanged
Manager, Member Liaison Program	OC-41	COB	Unchanged
Manager, Member Outreach & Education	OC-41	COB	Unchanged
Manager, Member Outreach, Education and Provider Relations	OC-41	COB	Unchanged
Manager, MSSP	OC-41	COB	Unchanged
Manager, OneCare (Clinical, Customer Service, or Sales)	OC-41	COB	Unchanged
Manager, OneCare Regulatory	OC-41	COB	Unchanged
Manager, Outreach & Enrollment	OC-13	COB	Unchanged
Manager, PACE Center	OC-06	COB	Unchanged
Manager, Payroll & Benefits	OC-01	COB	Deleted
Reason: Deleting position since it no longer exists in CalOptima.			
Manager, Pharmacy Operations	OC-20	COB	Deleted
Reason: Deleting position since it no longer exists in CalOptima.			
Manager, Process Excellence	OC-41	COB	Unchanged
Manager, Program Implementation	OC-06	COB	Unchanged
Manager, Project Management	OC-06	COB	Unchanged
Manager, Provider Data Management Services	OC-41	COB	Unchanged
Manager, Provider Network	OC-41	COB	Unchanged
Manager, Provider Relations	OC-41	COB	Unchanged
Manager, Provider Services	OC-41	COB	Unchanged
Manager, Purchasing	OC-01	COB	Unchanged
Manager, QI Initiatives	OC-41	COB	Unchanged
Manager, Quality Analytics	OC-06	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: Other misc authorities, districts and commissions

Agency: CalOptima

Position	Disclosure Category	Files With	Status
Manager, Quality Improvement	OC-41	COB	Unchanged
Manager, Regulatory Affairs and Compliance	OC-41	COB	Unchanged
Manager, Reporting & Financial Compliance	OC-01	COB	Unchanged
Manager, Strategic Development	OC-41	COB	Unchanged
Manager, Strategic Operations	OC-41	COB	Unchanged
Manager, Utilization Management	OC-06	COB	Unchanged
Medical Case Manager	OC-41	COB	Unchanged
Medical Director	OC-01	COB	Unchanged
OneCare Operations Manager	OC-41	COB	Unchanged
Pharmacy Services Specialist	OC-20	COB	Unchanged
Pharmacy Services Specialist, Int.	OC-20	COB	Unchanged
Pharmacy Services Specialist, Sr.	OC-20	COB	Unchanged
Program Manager	OC-06	COB	Unchanged
Program Manager Sr.	OC-06	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Project Manager	OC-06	COB	Unchanged
Project Manager, Lead	OC-06	COB	Unchanged
Project Manager, Sr.	OC-06	COB	Unchanged
QI Nurse Specialist (RN or LVN)	OC-06	COB	Unchanged
Regulatory Affairs and Compliance Analyst	OC-41	COB	Unchanged
Regulatory Affairs and Compliance Analyst Sr	OC-41	COB	Unchanged
Regulatory Affairs and Compliance Lead	OC-41	COB	Unchanged
Senior Manager, Government Affairs	OC-06	COB	Unchanged
Special Counsel	OC-01	COB	Unchanged
Sr. Director Regulatory Affairs and Compliance	OC-01	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Sr. Manager Financial Analysis	OC-01	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Sr. Manager Human Resources	OC-11	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Sr. Manager Information Services	OC-08	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Sr. Manager Provider Network	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Staff Attorney	OC-01	COB	Unchanged
Supervisor Behavioral Health	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor Credentialing	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor Dietary Services (Pace)	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor Disease Management	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor Nursing Services (Pace)	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor Provider Relations	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, Social Work (PACE)	OC-41	COB	Unchanged
Supervisor, Accounting	OC-01	COB	Unchanged
Supervisor, Audit and Oversight	OC-01	COB	Unchanged
Supervisor, Budgeting	OC-01	COB	Unchanged
Supervisor, Case Management	OC-41	COB	Unchanged
Supervisor, Claims	OC-06	COB	Unchanged
Supervisor, Coding Initiatives	OC-06	COB	Unchanged
Supervisor, Customer Service	OC-06	COB	Unchanged
Supervisor, Data Entry	OC-06	COB	Unchanged
Supervisor, Day Center (PACE)	OC-06	COB	Unchanged
Supervisor, Encounters	OC-06	COB	Unchanged
Supervisor, Facilities	OC-41	COB	Unchanged
Supervisor, Finance	OC-01	COB	Unchanged
Supervisor, Grievance and Appeals	OC-41	COB	Unchanged
Supervisor, Health Education	OC-06	COB	Unchanged
Supervisor, Health Services	OC-06	COB	Deleted
Reason: Deleting position since it no longer exists in CalOptima.			

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Supervisor, Information Services	OC-08	COB	Unchanged
Supervisor, Long Term Support Services	OC-41	COB	Unchanged
Supervisor, Member Outreach and Education	OC-41	COB	Deleted
Reason: Deleting position since it no longer exists in CalOptima.			
Supervisor, MSSP	OC-06	COB	Unchanged
Supervisor, OneCare Customer Service	OC-06	COB	Unchanged
Supervisor, Payroll	OC-06	COB	Unchanged
Supervisor, Pharmacist	OC-20	COB	Unchanged
Supervisor, Pharmacy Services	OC-20	COB	Deleted
Reason: Deleting position since it no longer exists in CalOptima.			
Supervisor, Provider Enrollment	OC-06	COB	Unchanged
Supervisor, Quality Analytics	OC-06	COB	Unchanged
Supervisor, Quality Improvement	OC-41	COB	Unchanged
Supervisor, Regulatory Affairs and Compliance	OC-06	COB	Unchanged
Supervisor, Systems Development	OC-08	COB	Unchanged
Supervisor, Therapy Services (PACE)	OC-41	COB	Unchanged
Supervisor, Utilization Management	OC-06	COB	Unchanged

Total: 213

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code, but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB	Unchanged
Chief Executive Officer	Files with	COB	Unchanged
Chief Financial Officer	Files with	COB	Unchanged
Member of the Board of Directors	Files with	COB	Unchanged

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

Disclosure Descriptions
EXHIBIT B (Working Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Disclosure Category	Disclosure Description	Status
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq.*.	Unchanged
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).	Unchanged
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.	Unchanged
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.	Unchanged
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.	Unchanged
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.	Unchanged
OC-30	Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest category in the code subject to the following limitation: The County Department Head/Director/General Manager/Superintendent/etc. may determine that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure required. The determination of disclosure is a public record and shall be filed with the Form 700 and retained by the Filing Officer for public inspection.	Unchanged

Disclosure Descriptions
EXHIBIT B (Working Draft)

Entity: Other misc authorities, districts and commissions

Agency: CalOptima

Disclosure Category	Disclosure Description	Status
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged

Grand Total: 9

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
21. Consider Authorizing CalOptima to Explore Policy Opportunities to Carve-In Dental Benefits for CalOptima Medi-Cal Members in Orange County

Contact
Michael Schrader, Chief Executive Officer, (714) 246-8400
Arif Shaikh, Director, Government Affairs, (714) 246-8400

Recommended Action
Authorize staff to explore policy opportunities to carve in dental benefits for CalOptima's Medi-Cal members in Orange County.

Background
The California Department of Health Care Services (DHCS) is responsible for administering dental benefits to eligible Medi-Cal beneficiaries. Denti-Cal is the part of Medi-Cal that covers dental services for Medi-Cal beneficiaries. DHCS has two different models for delivering dental services:

1) Fee-For-Service (FFS): Beneficiaries receive dental services from any licensed dental provider enrolled in Denti-Cal who accepts Medi-Cal payments and agrees to see them.
2) Dental Managed Care (DMC): Medi-Cal pays dental plans a set amount per member per month, and enrollees may only receive services from providers who are within the plan's provider network.

Currently, there are two counties in California (Sacramento and Los Angeles) that have a DMC model. The DMC model is mandatory in Sacramento County, where Medi-Cal beneficiaries are mandatorily enrolled in a DMC plan. A mandatorily enrolled Medi-Cal beneficiary may opt out of their DMC plan via the Beneficiary Dental Exception (BDE) process and move into FFS Denti-Cal, where the beneficiary may select his/her own dental provider. In Los Angeles County, beneficiaries are automatically enrolled in FFS Denti-Cal and must opt in to participate in the DMC program.

On June 27, 2018, Gov. Brown signed Senate Bill 849 (Chapter 47, Statutes of 2018), which authorized a dental integration pilot program in San Mateo County. The pilot program will be designed to test the impact on access, quality, utilization and cost when dental care is a managed care benefit overseen by the Health Plan of San Mateo (HPSM). Like CalOptima, HPSM is a County Organized Health System (COHS). The start date for the HPSM dental pilot program is July 1, 2019, subject to appropriation of funding by the Legislature, and, federal approval.

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Discussion

Dental and medical services have traditionally been delivered by separate systems despite evidence linking dental health and overall health. This is true in Orange County, with beneficiaries enrolled in CalOptima for medical benefits and FFS Denti-Cal for their dental benefits. In FFS Denti-Cal, patients access dental care on their own and no supporting infrastructure currently exists to allow integration between the medical and dental systems to coordinate a patient's overall health needs. According to a recent study by the Little Hoover Commission, utilization of dental benefits for Medi-Cal beneficiaries is low, due primarily to a shortage of dental providers who participate in the program.

With Board authorization, staff will undertake a three-pronged approach to exploring policy opportunities to carve-in dental benefits:

1) Engage local stakeholders, including the Orange County Dental Society, to discuss opportunities for CalOptima to develop a dental provider network aimed at increasing access to dental care for Orange County's Medi-Cal members;
2) Engage regulators and statewide advocacy organizations, including DHCS and the California Dental Association, to determine their level of support for policy solutions that integrate dental benefits into Medi-Cal managed care in Orange County; and
3) Engage members of the Orange County delegation to identify opportunities through the state legislative process.

Staff will bring back the results of the policy exploration to your Board for future consideration and planning of next steps.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

As the COHS for Orange County, CalOptima has a strong interest in ensuring the health and well-being of our community. Though the Little Hoover Commission found that the dental system in the Medi-Cal program is "broken," staff believes that there are many opportunities for CalOptima to work together with dental provider partners, regulators and other stakeholders to improve the delivery system in Orange County. Integrating dental and medical services for beneficiaries is likely to boost access to care and improve overall coordination of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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Board of Directors Meeting
November 1, 2018

Special Joint Member Advisory Committee, OneCare Connect Member Advisory Committee and Provider Advisory Committee Update

October 11, 2018 Joint Member Advisory Committee (MAC) OneCare Connect Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC) Meeting

At the Board's request, the MAC and PAC scheduled a special joint meeting to consider the important topics of the possible review of the CalOptima Delivery System, and a possible change to the Auto-Assignment Cap currently in place on the CalOptima Community Network. Eleven (11) MAC members and twelve (12) PAC members attended the October 11, 2018 Special Joint Meeting of the Advisory Committees. A number of OCC MAC members also attended the joint meeting but did not reach quorum.

At the special joint meeting, the MAC and the PAC discussed the directives issued by the Board at its September 6, 2018 meeting. MAC and PAC had extended discussion on both the possible evaluation of the Delivery System and the CalOptima Community Network Member Auto-Assignment Cap. While these items were considered separately, following extended discussion, the MAC and PAC were of one mind on these issues, with the two committees making similar recommendations. In addition to hearing from the committee members, MAC and PAC heard four public comments on the Delivery System recommendation and three additional public comments and two written comments on the Auto Assignment cap. The written public comments are attached to this report for your reference.

Delivery System

After extended discussion among MAC and PAC members regarding the Delivery System evaluation recommendation. PAC and MAC members unanimous voted to recommend against the proposal of hiring a consultant and conducting an evaluation of the Delivery System. Among the concerns raised were the lack of a clear estimate of costs associated with a consultant, costs to initiate a Request for Proposal (RFP) and the impact to CalOptima's staff resources to develop a new Delivery System. In addition, the Committees expressed concerns about the timing of the recommendation, considering that it could disrupt the agency's (and its provider partners) from focusing on upcoming important initiatives, including the Whole-Child Model and the Health Homes Programs. The Committees also noted the effectiveness of the current delivery system, which was recently ranked the top rated Medi-Cal plan in the State for the fifth consecutive year. Other concerns voiced were that the evaluation process and review could be distracting to both staff and CalOptima's provider partners and could lead to member confusion and disruption of member care.

Auto-Assignment Cap

After hearing public comments, a spirited discussion ensued about the differences between the CalOptima Community Network (CCN) and the other health networks, and what the difference

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was for the members. By way of background, and to provide the Committee members with additional context about the original intent of the program, PAC Member Jensen read a portion of the original CalOptima Ordinance that stated:

> *"It is not intended that Health Authority compete with private sector health plans individually or through joint ventures to offer insurance directly to individual or group private payers, procuring their coverage in the commercial, not governmental health care market."*

She noted that this topic had surfaced many years later when there was discussion by the Board on whether CalOptima should participate in the State's health care exchange for the Affordable Care Act. At that time the Board reiterated the same sentiment by stating:

> *"The Health Authority shall not have the power to offer a health insurance product in competition with private managed care organizations or private insurance plans in any health insurance exchange created pursuant to the provision of California government code sections 100500-100521 or similar States that may be enacted unless that product is intended to serve Medi-Cal eligible, Healthy Families eligible or other low income or indigent persons in obtaining health care."*

With this additional insight, the Committees engaged in additional discussion and unanimously voted to recommend against modifying the existing cap on CCN auto-assignment, concluding that leaving the cap as is would not impact CalOptima Members. PAC and MAC members also wanted to clarify that the cap has no impact on Member choice of selecting a provider, as Members have the option of selecting their preferred network and primary care provider when they first become eligible for CalOptima, and Members have the option each month of changing from their current provider and network if they so desire.

The MAC and PAC thank the Board for seeking their input on these important topics. The Committees have another joint meeting scheduled in November and always welcome opportunities to provide input on topics the Board is considering.

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Fountain Valley Regional
HOSPITAL & MEDICAL CENTER
Your hospital, your well-being

October 11, 2018

HAND DELIVERED

Ms. Sally Monar, Chair
CalOptima Member Advisory Committee
John H. Nishimoto, O.D., MBA, F.A.A.O., Chair
CalOptima Provider Advisory Committee
505 City Parkway West
Orange, CA 92868

RE: COMMENTS ON RECOMMENDATIONS RELATED TO (A) CALOPTIMA'S DELIVERY SYSTEM AND (B) CHANGES TO THE MEMBER AUTO-ASSIGNMENT LIMITS FOR THE CALOPTIMA COMMUNITY CARE NETWORK (CCN)

Dear Ms. Monar and Dr. Nishimoto:

On behalf of Fountain Valley Regional Hospital and Medical Center, I am pleased to submit these comments for consideration by your advisory committees, the CalOptima Board of Directors and senior leadership on the above-referenced recommendations, which are scheduled to return to the Board for additional discussion and/or action at its November 2018 meeting.

Fountain Valley Regional has been a major provider partner and strong supporter of CalOptima since the program's inception, and our hospital's role has steadily increased to become CalOptima's largest private hospital traditional and safety net partner. We take this obligation and commitment seriously and we maintain an outstanding record of providing efficient, quality healthcare services along with our physician and other partners (via the original Physician-Hospital Consortia model).

It is from this perspective we offer these comments on the pending recommendations.

RECOMMENDATIONS RELATED TO CALOPTIMA'S DELIVERY SYSTEM

We strongly support periodic, systemic, and transparent comprehensive reviews of CalOptima's delivery system and which should be conducted at regular intervals.

This is critical if one believes, as we do, that state-federal Medicaid funding will almost surely decline in future years. We must remember at all times that California's Medi-Cal program remains chronically underfunded; and, any and all efforts should be made to maximize the amount of resources that can be invested – or reinvested via savings – into efficient, higher quality care for CalOptima members.

Orange County has a de facto private safety net; and, CalOptima should continue to work closely with those who have shown the most commitment and dedication in preserving it for all residents, rich and poor alike. Therefore, we need to be planning together to best position CalOptima's delivery system to ensure that CalOptima – as a steward of taxpayer funds – is utilizing every dollar as effectively and efficiently as possible by investing in and incentivizing only in healthcare delivery models that ensure such a result.

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Today, many such proven models involve provider partners assuming "risk" and it is in CalOptima's best long term interest to continue to delegate such risk to those community partners willing and able to do so in order to maximize the use of these public funds.

Delivery of healthcare today also includes many dominant, well proven operational and patient management principles including utilization review and management and a wide array of patient and quality-related outcome metrics. Government also continues to tilt incentives heavily toward aligning all providers of care (i.e., value based care and other payment models), which should remain a prerequisite for CalOptima's future healthcare delivery design, including continued assignment of risk.

In our opinion, CalOptima should ensure that its members benefit from – and are directed for services in – such efficient, higher quality systems of care, which we deploy and utilize for all patients, whether commercial, government-sponsored (Medicare and Medi-Cal) or uninsured.

We are therefore pleased that all forms of network delivery of care within CalOptima will be included in the review. We also strongly encourage the addition of any and all relevant metrics not already collected for CCN and other networks, such as, hospital length of stay, readmission rates, member complaints and provider grievance and appeals.

Only a true "apples-to-apples" comparison will identify for CalOptima, its Board and community stakeholder partners, the most efficient and higher quality delivery models; and, serve as a basis for future planning and reviews. In short, the "dashboard" comparing delivery networks or models of care should be as comprehensive and meaningful as possible. Importantly, risk adjustment for complexity of illness should be a key factor in any analysis.

Finally, we hope this review will identify – and recommend solutions for – gaps in our delivery system for CalOptima's members and how we might invest and organize solutions. The results should enable CalOptima to appropriately leverage, utilize, incentivize and support its partners that are proven to provide higher quality and efficient care (as well as recognize those who remain committed to doing so for the long term). Such an approach will also enable CalOptima to reinvest savings from more efficient, quality delivery of care toward the long-term stability of its overall provider network.

RECOMMENDATIONS RELATED CHANGES TO THE MEMBER AUTO-ASSIGNMENT LIMITS FOR THE CALOPTIMA COMMUNITY CARE NETWORK

We believe any proposal to modify CalOptima's existing auto-assignment methodology and policy, including lifting the current cap on the Community Care Network (CCN), should not be considered in a vacuum (and as a single, separate question); and, instead should be more thoroughly analyzed and reviewed as part of the overall delivery system analysis that will be conducted.

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CCN was originally established to manage patients already in the CalOptima Direct network, patients that were "unmanaged". The overall delivery system review will better enable the Board to determine whether continuing to grow CCN is the most efficient use of public funds because we will be able to compare CCN's overall performance on critical metrics with other networks of care.

For example, data was recently presented to the CalOptima Board detailing ongoing member disenrollment rates from various networks following their initial auto assignment to another network. Some may argue this should justify permitting CCN to grow even larger. We believe additional analysis would be illustrative about the "disenrollment dynamic". For example, is there is a predominate subset of CCN physicians that members are realigning to? Are those physicians also in other networks? Following disenrollment by patients, is the utilization of services impacted? Are such members more or less likely to have more complex or chronic illnesses or conditions?

We also believe that, in undertaking a more comprehensive review of the auto-assignment policy, CalOptima could take the opportunity to modernize the policy and align such changes with the results of the larger, delivery system analysis. Ultimately, two primary drivers of auto assignment of members should be assigning patients to CalOptima's most efficient partners; and, to target assignments to those providers who consistently have taken on a larger share of traditional and safety net obligations with and for CalOptima members.

In closing, be assured that Fountain Valley Regional, and our parent company (Tenet Healthcare), remain committed to CalOptima and Orange County's de facto private safety net. We look forward to additional opportunities to provide care delivery insights and comments to your advisory committees, Milliman and others in the coming weeks and months. Thank you for considering our views on these important and germane issues.

Sincerely,

Kenneth McFarland
Chief Executive Officer

cc: Members, CalOptima Board of Directors
Members, CalOptima Member and Provider Advisory Committees
Michael Schrader, CEO, CalOptima
Other Interested Parties

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To: Members, Board of Directors, CalOptima
Members, Provider Advisory Committee
Members, Member Advisory Committee

October 4, 2018

Dear Respected Leaders,

We are writing this letter to express our **SUPPORT in lifting the cap** of the auto-assignment for the CalOptima Community Network (CCN).

CalOptima has two primary models of contracting with providers: delegation to health networks and direct contracts with individual physicians. CalOptima launched its direct contracting model, known as CalOptima Community Network (CCN), in 2014, with the goal of ensuring an adequate provider network to serve CalOptima's membership, which was growing significantly at that time due to the state's expansion of Medi-Cal after passage of the federal Affordable Care Act (ACA). New members who join CalOptima have the option of choosing their health network and their primary care physician (PCP). If the new member does not select a health network, then CalOptima "auto assigns" the member into one of CalOptima's networks.

Since the establishment of CCN, there has been a policy of stopping auto assignment of members into CCN once its total enrollment reaches 10% of CalOptima's total membership while the health networks could continue receiving patient assignments. **We find this to be totally unfair and are recommending this unmerited cap to be lifted!!**

CalOptima's mission states that it wants to expand access to members and ensure maximal physician participation. If that's the case, you need to keep the CCN going and give physicians and members the choice to participate. Here are few reasons why the CCN cap needs to be removed to ensure member access and physician participation.

- CCN providers takes the worst-case scenario patients (complex patients) including patients with hemophilia, end stage renal disease, cystic fibrosis, muscle dystrophy, organ transplant, and more - the health networks do not. Why then do we need to limit access for these members?
- CCN has the greatest number of unique physicians – meaning they do not participate in the other health networks, only CCN. This is proof that without the CCN, members would not have access and it would restrict access for members.
- The more options CalOptima provides for physicians to participate in the CalOptima delivery system, the more physicians who would be willing to participate - which means expanded access.
- Even among the general CalOptima membership, staff data suggests that the CCN takes more complex members.
- For any provider to remain engaged, they must have access to members, which means the CCN needs to be continually refreshed.

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- CCN is on a fee for service plan, but is in a managed care model with the very same principles as a health network. This includes members being assigned to PCPs, utilization review processes, case management, and care coordination.
- Based on staff analysis, removing the 10% auto assignment cap CCN would have minimal impact on medical and administrative expenses. Additionally, only 7.8% of members would be auto assigned to CCN, while 92.2% of members would continue to be auto assigned to delegated health contracts.

On a more personal note, I am disappointed at the conversations I am hearing about providers. Often times we talk about CalOptima providers and think about the Health Networks (HN), but we forget about the THOUSANDS of physicians who are providing care daily on the front lines. Despite the fact the auto assignment is off, CalOptima members are still voluntarily opting to enroll in the CCN which is a sign of their desire to remain in the CCN and relationship they have with their physician provider, not health network.

I hope you will join the thousands of physicians providing exceptional access and care to the most vulnerable members of our community, by voting in **SUPPORT of lifting the cap** of the auto-assignment for the CalOptima Community Network (CCN).

Thank you for the privilege of your time.

Sincerely,

Nikan Khatibi
Physician
Board Member, CalOptima – representing the community physician seat

Chris Cellio MD
Family Medicine Physician

Annu Sharma MD
Pediatric Physician

Smita Tandon MD
Pediatric Physician

James Streibig MD
Internal Medicine Physician

Brennan Cassidy MD
Family Medicine Physician

Bob Sankaram MD
Nephrologist

Samara Cardenas MD
Pediatric Physician

Quynh Kieu MD
Pediatric Physician

Ray Garcia Lora MD
Pediatric Physician

Raman Chopra MD
Pediatric Physician

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June 25, 2018

Dear Members of the Board of Directors, Provider Advisory Committee, and Member Advisory Committee:

I **vote in support** of lifting the cap on the auto assignment for CCN.

This cap is at odds with the mission of CalOptima to expand access to its members and increase physician participation. I am a physician located in Irvine and participate only with CCN for CalOptima. Over the last 25 years of private practice I was involved in many global volunteer missions including to Africa, South America, India and Armenia.

In 2011, after coming back from a trip I felt the need, to help with access to medical care, for families in need, in my own community of Irvine. With that thought in mind I proceeded to obtain a contract with CalOptima Direct which subsequently brought in the option of CCN. I now have several CCN patients with some complex cases like Lennox Gastaut, Infantile Spinal Muscular Atrophy, Isovaleric Acidemia to name a few.

In order to be involved, providers must have access to a wide variety of cases. A lot of our CalOptima Patients seek us out and voluntarily opt to enroll in CCN to see us. CCN must remain viable in order for providers like me to continue to offer services to the families in our community.

"The unmerited cap of 10% on CCN needs to be lifted!"

Warm regards,

Annu G Sharma MD

Past Chairman Department of Pediatrics
Hoag Hospital Newport Beach CA 92663
Chair Information Technology
American Academy of Pediatrics California Chapter
Physician of Excellence honoree 2018-2019
Orange County Medical Association
HEALTH 4 KIDZ PEDIATRIC
'Healthy kids are Happy kids'
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Board of Directors Meeting
November 1, 2018

CalOptima Foundation Update

Background

In 2010, the CalOptima Foundation (the Foundation) was incorporated as a 50l(c)(3) nonprofit charitable organization. The specific purpose for which the Foundation was incorporated is "to assist in performing the functions and carrying out the programs of CalOptima." The initial focus of the Foundation was to apply for federal grant funding to operate the CalOptima Regional Extension Center (COREC), which was designed to support implementation of electronic health record systems in provider offices. To date, the Foundation's activities have centered around the administration of the approximately $6.7 million federal COREC grant.

Near the Foundation's inception, it entered into an administrative services agreement with CalOptima under which CalOptima would provide certain administrative and technical services in exchange for payment from the Foundation.

Shortly after the Foundation's establishment, the CalOptima Board of Directors undertook a strategic planning process focused on unmet needs in the community impacting the health of CalOptima's members. To address those needs, CalOptima's Board approved the 2013–16 Strategic Plan, aimed in part at providing support for expanding the Foundation.

In March 2014, the CalOptima Board authorized a one-time $3 million transfer to the Foundation from CalOptima's net assets in the fiscal year 2013–14 budget. An expenditure plan was approved a few months later, stating that the intent was to use those transferred dollars for these primary purposes:

- Sustaining and expanding COREC activities ($1.2 million)
- Community health grants to strengthen the safety net, enhance preventative services and support wraparound services for CalOptima members ($1.5 million)
- Administrative expenses ($300,000)

The original federal COREC funds were largely exhausted in fall 2015. As part of the COREC grant, a deliverable included a sustainability plan. CalOptima was interested in pursuing a continuation and extension of COREC services in part because of this sustainability plan requirement. Separate and apart from the Foundation, CalOptima (the public agency subsequently applied for and was awarded a separate $4.3 million state grant. (The state grant did not require a 501(c)(3) nonprofit charitable organization to apply for the funds.)

CalOptima, the public agency, began directly administering the newly-named electronic health record project, CalOptima Technical Assistance Program (COTAP). With the exhaustion of the original COREC federal grant made to the Foundation, the Foundation is not involved in the COTAP project activities.

At this stage, the majority of $3 million in funds transferred from CalOptima to the Foundation remain unexpended, with a balance of approximately $2.8 million, as of September 2018.

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Foundation Status and Future Options

Amid the shift from COREC to COTAP and anticipating the need to address the status and future of the Foundation, the CalOptima Board (acting as the Foundation Board) suggested further discussion via the formation of an Ad Hoc committee. Ad Hoc members Peter Agarwal, Supervisor Lisa Bartlett and Supervisor Andrew Do met on July 7, 2015, to review the following:

- The purpose for creation of the Foundation
- Activities of the Foundation
- Approval of transferring funds from CalOptima (the public agency)
- Impacts and consequences of continuing the Foundation
- Comparison with other public health plan Foundation or community benefit programs

The Ad Hoc committee requested further study in several areas. CalOptima staff researched the topics and provided the following information:

- An organization either is *or* is not qualified under Internal Revenue Code section 501(c)(3) for tax exemption; there is no "inactive" status.

    - An organization with 501(c)(3) status may exist indefinitely without conducting any of the activities related to the purpose for which it was created, as long as administrative duties, such as filing tax returns and other state filings are completed. An exempt organization may be suspended and have its tax exemption revoked for not conducting these administrative functions and filing proper documents.

The administrative cost to maintain exempt status for the Foundation is nominal. Costs include the filling of the state and federal tax forms annually, the Attorney General's Registry of Charitable Trust form (RRF-1) annually, and the Secretary of State registration form (SI-100) every two years.

    - The transfer of funds between two tax-exempt entities (CalOptima, the public agency, and CalOptima Foundation) does not generate any tax consequences.

Further discussion and action about the Foundation was sidelined in conjunction with the appointment of a new CalOptima Board in July 2016.

Options for Consideration

At their August 2018 meeting, CalOptima Board members expressed a renewed interest in the status and options for the Foundation moving forward. The following are potential options for the Foundation:

Option 1 - Continue Foundation Operations

Since the original intent of the funds transferred to the Foundation was to support COREC and community health grants, those dollars may be directed to be used for similar purposes — to establish a community benefit program for grant making, similar to the community grants being made by CalOptima through the Rate Range Intergovernmental Transfer (IGT) program, assuming the focus of

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such a program is consistent with the purpose of assisting CalOptima in performing its functions and carrying out CalOptima's programs.

This option would continue operation of the CalOptima Foundation as a 50l(c)(3) nonprofit charitable organization and provide a vehicle for future grant opportunities that require 50l(c)(3) nonprofit status in order to apply. Additionally, given the changes to the allowable use of the Rate Range Intergovernmental Transfer (IGT) program dollars, this option would provide a platform from which to continue grant making efforts that support the CalOptima program. The Board and staffing of the Foundation may be reconsidered in order to maximize the fundraising potential and future grant making activities of the Foundation. Apart from the dollars currently in the Foundation's accounts, a responsibility of the Foundation would be raising/generating its own funds. As a means of expediting formation, a decision was initially made for the CalOptima Board members to appoint themselves as the members of the Foundation board of directors; however, under this scenario, it would be within the CalOptima Board's discretion to appoint others to serve on the Foundation board where such individuals could potentially have greater focus on Foundation activities (e.g., fund raising activities from sources available only to 50l(c)(3) nonprofit charitable organizations such as the COREC grant) in support of CalOptima's mission and programs.

Option 2 - Spend the Foundation Assets and Dissolve the Foundation

The CalOptima Foundation may consider making community health grants from the remaining funds for purposes as similar to Option 1 above. With no remaining assets and grant reporting finalized, the process of winding down the Foundation could be initiated by a resolution of the Foundation Board. Some additional steps will be required, including:

- Filing a certificate of election to dissolve with the California Attorney General
- Reviewing and retiring Foundation activities and policies, and distributing any other remaining assets
- Filing a certificate of dissolution with Secretary of State
- Filing a final dissolution packet with California Attorney General
- Filing final tax returns

Option 3 – Return Assets to CalOptima (Health Plan) and Dissolve the Foundation

At this stage, the COREC initiative has been completed. As the funds provided by CalOptima to the Foundation were not utilized as intended, those funds may be returned to CalOptima as part of the winding down process, including compliance with the requirements of the California Secretary of State and Attorney General, and the additional steps as noted above.

Attachments

1. March 6, 2014 CalOptima Board Action Agenda Referral, Item VI. E., Approve Proposed Work Plan for CalOptima Foundation and Approve Transfer of Fiscal Year 2013-14 Budget Allocation to CalOptima Foundation
2. September 4, 2014 CalOptima Foundation Board Action Agenda Referral, Item VII. E. Authorize the Fiscal Year (FY) 2014-15 CalOptima Foundation Expenditure Plan

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken March ~~7~~ 6, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. E. Approve Proposed Work Plan for CalOptima Foundation and Approve Transfer of Fiscal Year 2013-14 Budget Allocation to CalOptima Foundation

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve proposed work plan for CalOptima Foundation; and
2. Approve transfer of a $3 million Fiscal Year 2013-14 budget allocation to the CalOptima Foundation.

Background

The CalOptima Foundation obtained 501(c)(3) designation in 2010 as part of a successful effort to seek Federal funding to operate the CalOptima Regional Extension Center (COREC). It is governed by the CalOptima Board, acting in its capacity as the Foundation Board an average of two to four times per year to conduct business relating to COREC and required annual functions (e.g., budget, audit). Currently, the Foundation's activities include the administration of the COREC grant which was awarded to CalOptima by the U.S. Department of Health and Human Services' Office of the National Coordinator to assist primary care physicians implement electronic medical record systems.

In conjunction with CalOptima's Board-approved 2013-16 Strategic Plan, expanding the function of the Foundation to complement the work of the health plan in better serving members is a strategic objective under the Financial Stability priority. The Fiscal Year 2013-14 budget includes a $3 Million set-aside for the Foundation.

Discussion

Current and planned Foundation activities include:

- Sustaining and expanding COREC services to increase meaningful use of electronic health records by primary and specialty care physicians serving Medi-Cal members;
- Transitioning current development and community-centered activities to the Foundation for greater plan efficiency, including:
    - Increasing provider capacity and incubating emerging programs or models that address unmet community needs;
    - Supporting community programs, such as community health promotion and Medi-Cal outreach and enrollment events;
- Pursuing federal and foundation grants and partnering with community groups on solutions to healthcare gaps.

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A high-level work plan for Foundation expansion planning is included in the attached presentation. Staff recommends proceeding with implementation of the proposed work plan during the current fiscal year, with funding commitments consistent with the Foundation's filing status and available funding taking place in FY 2014-15.

Fiscal Impact
The recommended action would result in an estimated expenditure of $3 million for CalOptima Foundation which would be funded from CalOptima reserves as established in June 2013.

Rationale for Recommendation
Continuation and expansion of the CalOptima Foundation's functions to support activities that address service gaps experienced by CalOptima members and the community is consistent with the Board-approved 2013-16 Strategic Plan. These activities also complement current efforts to implement health information technology to improve delivery and coordination of care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *2/28/2014*
Authorized Signature — **Date**

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CALOPTIMA FOUNDATION BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 4, 2014
Meeting of the CalOptima Foundation Board of Directors

Report Item
VII. E. Authorize the Fiscal Year (FY) 2014-15 CalOptima Foundation Expenditure Plan

Contact
Michael Ruane, Executive Director, (714) 246-8400

Recommended Action
Authorize the FY 2014-15 CalOptima Foundation Expenditure Plan.

Background and Discussion

Foundation History and Role
The CalOptima Foundation (Foundation) obtained 501(c)(3) designation in 2010 as part of a successful effort to seek federal funding to operate the CalOptima Regional Extension Center (COREC). It is governed by the CalOptima Board, acting in its capacity as the Foundation Board an average of 2 to 4 times per year to conduct business and required annual functions (e.g., budget, audit). Currently, the Foundation's activities center on the administration of the COREC grant.

Foundation Expansion Planning
In conjunction with CalOptima's Board-approved 2013-16 Strategic Plan, expanding the function of the Foundation to complement the work of CalOptima the health plan in better serving members is a strategic objective under the Financial Stability priority. The Board-approved Fiscal Year 2014-15 CalOptima budget includes a $3 million set-aside for the Foundation.

In March 2014, CalOptima's Board approved a high-level work plan for Foundation expansion with funds allocated to two main categories: (1) the expansion of COREC services and (2) implementation of a Community Health Grant Program.

Extension of COREC Services – Approved Amount: $1.2 Million

The COREC grant was awarded to the CalOptima Foundation by the U.S. Department of Health & Human Services, Office of the National Coordinator for Health Information Technology, to assist Orange County healthcare providers with implementation of electronic health record (EHR) systems and attainment of meaningful use certification. Meaningful use refers to providers' ability to use EHR technology to improve quality, safety and efficiency.

Federal guidelines define three tiers of progressively more sophisticated meaningful use criteria, described generally as follows:

- Stage 1: Capture data and share internally
- Stage 2: Share information with multiple providers, including specialists and hospitals
- Stage 3: Show documented improvement in patient outcomes.

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Consistent with these requirements, the COREC has worked with approximately 1,000 Orange County Primary Care Providers (PCPs) to achieve Stage 1 meaningful use and is assisting these providers with meeting Stage 2 criteria, which became more stringent in 2014. Many of these providers are requiring additional resources and technical assistance to meet the January 1, 2015 deadline for Stage 2 criteria and avoid a 1 percent cut to their Medicare reimbursement; this support is being funded through IGT funds.

With the approved Foundation funding, COREC will extend its services as follows:

- Provide meaningful use supports for 114 PCPs and 430 specialists (program is currently limited to PCPs);
- Improve health care access and delivery, for example through enhanced clinical data analytics and assisting providers in adopting telemedicine delivery models.

It is anticipated that the full $1.2 million allocation will be applied toward costs associated with assisting provider practices to select and implement an EHR system and achieve federal meaningful use criteria of the new technology. COREC staffing costs are excluded from the Foundation budget since they were previously included as part of the approved CalOptima Medi-Cal FY 2014-15 Operating Budget.

Community Health Grant Program – Approved Amount: $1.8 Million

At its March 2014 meeting, CalOptima's Board designated funding to invest in promising practices and approaches to address community needs and gaps. Some options to explore include:

- Strengthening the safety net, for example by enhancing community clinic capacity;
- Expanding access to and use of preventive services, such as developmental, vision and dental screening;
- Providing wraparound services and promoting integration of services for vulnerable populations, such as homeless members and foster children.

To provide further guidance, staff has convened a MAC/PAC ad hoc subcommittee to review available data and provide recommendations for grant-making priorities. The group is scheduled to complete its work in the September - October timeframe. CalOptima subject matter experts will then review the group's input and propose a final set of funding recommendations (with corresponding budget amounts) to the Board for consideration.

Proposed Budget
The proposed CalOptima Foundation FY 2014-15 Expenditure Plan is presented in the table below. This budget includes a line item for general and administrative expenses related to administration of Foundation business, which was not specifically carved out in the preliminary budget presented to the Board in March 2014. Staff recommends that $300,000 be moved from the Community Health Program allocation for this purpose.

In accordance with accepted practices in nonprofit management, the Foundation's administrative costs will not exceed 10% of the total operating budget, or $300,000, for FY 2014-15. Salaries and benefits for 2.0 FTEs are the main expenditure. During the start-up period these expenditures may be utilized to reimburse current staffing costs, supports and Foundation activities. The scope of work for the

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proposed positions includes administering competitive grant processes for each of several funding priorities; developing agreements with grantees; monitoring grant performance; providing technical assistance to grantees; and reporting on grant outcomes.

Recommended FY 2014-15 CalOptima Foundation Expenditure Plan

	FY 2014-15 Budget
COREC:	
Professional fees for contracted service partners for technical assistance to PCPs and specialists	$1,200,000
Community Health Grant Program:	
Grants for select funding priorities	$1,500,000
Administrative Expenses:	
Salaries, Wages & Benefits	$210,000
Professional Fees	$50,000
Printing & Postage	$10,000
Other Operating Expenses	$30,000
Subtotal	$300,000
Total	$3,000,000

Fiscal Impact
The recommended action provides additional details on expenditures of the FY 2013-14 budget allocation of $3 million for the CalOptima Foundation, approved at the March 6, 2014 CalOptima Board meeting.

Rationale for Recommendation
Continuation and expansion of the CalOptima Foundation's functions to support activities that address service gaps experienced by CalOptima members and the community is consistent with the Board-approved 2013-16 Strategic Plan. These activities also complement current efforts to implement health information technology to improve delivery and coordination of care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

8/29/2014 — **Date**

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A Public Agency

CalOptima

Better. Together.

Financial Summary

September 2018

Board of Directors Meeting

November 1, 2018

Greg Hamblin

Chief Financial Officer

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FY 2018-19: Consolidated Enrollment

- September 2018 MTD:
  - ➢ Overall enrollment was 774,440 member months
    - Actual lower than budget 10,259 or 1.3%
      - Medi-Cal: unfavorable variance of 10,103 members
        - ➢ Temporary Assistance for Needy Families (TANF) unfavorable variance of 5,194 members
        - ➢ Medi-Cal Expansion (MCE) unfavorable variance of 4,230
        - ➢ Senior Persons with Disabilities (SPD) unfavorable variance of 586 members
        - ➢ Long-Term Care (LTC) unfavorable variance of 93
      - OneCare Connect: unfavorable variance of 210 members
    - 1,401 decrease from prior month
      - Medi-Cal: decrease of 2,936 from August
      - OneCare Connect: increase of 1,544 from August
      - OneCare: decrease of 9 from August
      - PACE: no change from August

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FY 2018-19: Consolidated Enrollment (cont.)

- September 2018 YTD:
  - Overall enrollment was 2,328,815 member months
    - Actual lower than budget 25,860 or 1.1%
      - Medi-Cal: unfavorable variance of 25,548 members or 1.1%
        - TANF unfavorable variance of 13,282 members
        - MCE unfavorable variance of 11,103 members
        - SPD unfavorable variance of 925 members
        - LTC unfavorable variance of 238 members
      - OneCare Connect: unfavorable variance of 503 members or 1.1%
      - OneCare: favorable variance of 177 or 4.5%
      - PACE: favorable variance of 14 members or 1.7%

FY 2018-19: Consolidated Revenues

- September 2018 MTD:
  - ➢ Actual lower than budget $3.2 million or 1.2%
    - Medi-Cal: unfavorable to budget $3.0 million or 1.2%
      - Unfavorable volume variance of $3.3 million
      - Favorable price variance of $0.2 million
    - OneCare Connect: unfavorable to budget $0.3 million or 1.4%
      - Unfavorable volume variance of $0.4 million
    - OneCare: favorable to budget $100.8 thousand or 6.3%
      - Favorable volume variance of $61.6 thousand
      - Favorable price variance of $39.2 thousand
    - PACE: favorable to budget $67.2 thousand or 3.3%
      - Favorable volume variance of $21.7 thousand
      - Favorable price variance of $45.5 thousand

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FY 2018-19: Consolidated Revenues (cont.)

- September 2018 YTD:
  - Actual lower than budget $0.9 million or 0.1%
    - Medi-Cal: unfavorable to budget $3.9 million or 0.5%
      - Unfavorable volume variance of $8.2 million
      - Favorable price variance of $4.4 million due to:
        - $4.7 million of FY18 LTC revenue from non-LTC aid codes
        - $3.3 million of FY18 Coordinated Care Initiative (CCI) revenue
        - $1.1 million of FY18 Applied Behavioral Analysis (ABA) revenue
        - $1.2 million of FY18 Hepatitis C revenue
        - ($5.9) million of FY19 non-LTC revenue from non-LTC aid codes
        - ($1.2) million of FY19 ABA revenue

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FY 2018-19: Consolidated Revenues (cont.)

- September 2018 YTD:
  - OneCare Connect: favorable to budget $3.7 million or 5.0%
    - Unfavorable volume variance of $0.8 million
    - Favorable price variance of $4.6 million related to prior year Part D revenue adjustment and $1.7 million from 2016 Quality Withhold payback
  - OneCare: Unfavorable to budget $1.0 million or 22.0%
    - Favorable volume variance of $0.2 million
    - Unfavorable price variance of $1.3 million due to Centers for Medicare & Medicaid Services (CMS) revenue adjustment as a result of calendar year 2016 Hierarchical Condition Category (HCC) reconciliation
  - PACE: favorable to budget $0.2 million or 3.7%
    - Favorable volume variance of $0.1 million
    - Favorable price variance of $0.1 million

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FY 2018-19: Consolidated Medical Expenses

- September 2018 MTD:
  - ➢ Actual lower than budget $9.0 million or 3.5%
    - Medi-Cal: favorable variance of $7.7 million
      - Favorable volume variance of $3.1 million
      - Favorable price variance of $4.7 million
        - ➢ Professional Claim expenses favorable variance of $9.3 million due to Child Health and Disability Prevention Program (CHDP) and Proposition 56 expenses recorded in Provider Capitation, Behavioral Health Treatment (BHT), and claims Incurred But Not Reported (IBNR) restatement
        - ➢ Prescription Drug expenses favorable variance of $3.2 million
        - ➢ Provider Capitation expenses unfavorable variance of $4.0 million due to Proposition 56 expense and CHDP that was budgeted in Professional Claim expenses
        - ➢ Facilities expenses unfavorable variance of $3.7 million due to higher inpatient and outpatient claims and IBNR restatement

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FY 2018-19: Consolidated Medical Expenses (cont.)

- September 2018 MTD:
  - OneCare Connect: favorable variance of $1.1 million or 4.7%
    - Favorable volume variance of $0.3 million
    - Favorable price variance of $0.8 million
  - OneCare: favorable variance of $48.0 thousand
  - PACE: favorable variance of $120.2 thousand

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FY 2018-19: Consolidated Medical Expenses (cont.)

- September 2018 YTD:
  - Actual lower than budget $7.1 million or 0.9%
    - Medi-Cal: favorable variance of $5.9 million
      - Favorable volume variance of $7.8 million
      - Unfavorable price variance of $2.0 million
        - Professional Claim expenses favorable variance of $14.3 million
        - Facilities expenses unfavorable variance of $11.6 million
        - Provider Capitation expenses unfavorable variance of $10.8 million
        - Prescription Drug expenses favorable variance of $4.6 million
    - OneCare Connect: favorable variance of $0.5 million
      - Favorable volume variance of $0.8 million
      - Unfavorable price variance of $0.3 million

- Medical Loss Ratio (MLR):
  - September 2018 MTD: Actual: 91.9% Budget: 94.0%
  - September 2018 YTD: Actual: 94.3% Budget: 95.1%

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FY 2018-19: Consolidated Administrative Expenses

- September 2018 MTD:
  - Actual lower than budget $2.8 million or 22.7%
    - Salaries, wages and benefits: favorable variance of $1.4 million
    - Other categories: favorable variance of $1.4 million

- September 2018 YTD:
  - Actual lower than budget $7.9 million or 20.8%
    - Salaries, wages & benefits: favorable variance of $4.1 million
    - Purchased Services: favorable variance of $1.2 million
    - Other categories: favorable variance of $2.6 million

- Administrative Loss Ratio (ALR):
  - September 2018 MTD: Actual: 3.4% Budget: 4.4%
  - September 2018 YTD: Actual: 3.6% Budget: 4.6%

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FY 2018-19: Change in Net Assets

- September 2018 MTD:
  - $14.1 million surplus
  - $9.3 million favorable to budget
    - Lower than budgeted revenue of $3.2 million
    - Lower than budgeted medical expenses of $9.0 million
    - Lower than budgeted administrative expenses of $2.8 million
    - Higher than budgeted investment and other income of $0.8 million

- September 2018 YTD:
  - $23.6 million surplus
  - $19.4 million favorable to budget
    - Lower than budgeted revenue of $0.9 million
    - Lower than budgeted medical expenses of $7.1 million
    - Lower than budgeted administrative expenses of $7.9 million
    - Higher than budgeted investment and other income of $5.4 million

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Enrollment Summary: September 2018

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
63,892	64,219	(327)	(0.5%)	Aged	191,296	191,985	(689)	(0.4%)
620	620	-	0.0%	BCCTP	1,862	1,860	2	0.1%
46,863	47,122	(259)	(0.5%)	Disabled	141,101	141,339	(238)	(0.2%)
311,532	315,672	(4,140)	(1.3%)	TANF Child	938,815	948,571	(9,756)	(1.0%)
94,075	95,129	(1,054)	(1.1%)	TANF Adult	282,899	286,425	(3,526)	(1.2%)
3,378	3,471	(93)	(2.7%)	LTC	10,142	10,380	(238)	(2.3%)
237,738	241,968	(4,230)	(1.7%)	MCE	713,489	724,592	(11,103)	(1.5%)
758,098	**768,201**	**(10,103)**	**(1.3%)**	**Medi-Cal**	**2,279,604**	**2,305,152**	**(25,548)**	**(1.1%)**
14,681	**14,891**	**(210)**	**(1.4%)**	**OneCare Connect**	**44,217**	**44,720**	**(503)**	**(1.1%)**
286	**283**	**3**	**1.1%**	**PACE**	**845**	**831**	**14**	**1.7%**
1,375	**1,324**	**51**	**3.9%**	**OneCare**	**4,149**	**3,972**	**177**	**4.5%**
774,440	**784,699**	**(10,259)**	**(1.3%)**	**CalOptima Total**	**2,328,815**	**2,354,675**	**(25,860)**	**(1.1%)**

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Financial Highlights: September 2018

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
774,440	784,699	(10,259)	(1.3%)	Member Months	2,328,815	2,354,675	(25,860)	(1.1%)
273,800,098	277,026,096	(3,225,998)	(1.2%)	Revenues	826,777,831	827,714,656	(936,825)	(0.1%)
251,502,394	260,513,607	9,011,213	3.5%	Medical Expenses	779,893,304	786,968,561	7,075,257	0.9%
9,390,986	12,154,367	2,763,380	22.7%	Administrative Expenses	29,910,746	37,782,748	7,872,002	20.8%
12,906,718	**4,358,122**	**8,548,596**	**196.2%**	**Operating Margin**	**16,973,781**	**2,963,347**	**14,010,434**	**472.8%**
1,187,626	416,667	770,959	185.0%	Non Operating Income (Loss)	6,620,944	1,250,000	5,370,943	429.7%
14,094,345	**4,774,789**	**9,319,556**	**195.2%**	**Change in Net Assets**	**23,594,724**	**4,213,347**	**19,381,377**	**460.0%**
91.9%	94.0%	2.2%		Medical Loss Ratio	94.3%	95.1%	0.7%	
3.4%	4.4%	1.0%		Administrative Loss Ratio	3.6%	4.6%	0.9%	
4.7%	1.6%	3.1%		Operating Margin Ratio	2.1%	0.4%	1.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: September 2018 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
12.1	5.0	7.1	Medi-Cal	14.7	5.9	8.8
0.4	(0.6)	1.0	OCC	2.3	(2.8)	5.1
0.1	(0.0)	0.2	OneCare	(0.8)	(0.2)	(0.6)
0.3	0.0	0.2	PACE	0.8	0.1	0.7
12.9	**4.4**	**8.6**	**Operating**	**17.0**	**3.0**	**14.0**
1.2	0.4	0.7	Inv./Rental Inc, MCO tax	6.6	1.3	5.4
1.2	**0.4**	**0.7**	**Non-Operating**	**6.6**	**1.3**	**5.4**
14.1	**4.8**	**9.3**	**TOTAL**	**23.6**	**4.2**	**19.4**

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Consolidated Revenue & Expense: September 2018 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	520,360	237,738	758,098	14,681	1,375	286	774,440
REVENUES							
Capitation Revenue	$ 135,130,436	$ 110,296,653	$ 245,427,089	$ 24,555,512	$ 1,701,094	$ 2,116,403	$ 273,800,098
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	135,130,436	110,296,653	245,427,089	24,555,512	1,701,094	2,116,403	273,800,098
MEDICAL EXPENSES							
Provider Capitation	36,001,129	50,216,249	86,217,378	11,050,443	384,233		97,652,054
Facilities	23,349,178	22,765,565	46,114,743	3,034,809	395,068	348,991	49,893,610
Ancillary	-	-	-	457,963	6,478	-	464,441
Professional Claims	13,627,334	4,965,744	18,593,078	-	-	472,748	19,065,826
Prescription Drugs	16,094,887	18,423,410	34,518,297	5,074,377	505,809	147,835	40,246,318
MLTSS	32,388,120	2,919,672	35,307,792	1,409,972	116,360	136	36,834,259
Medical Management	1,999,850	1,022,897	3,022,747	1,059,509	50,125	573,304	4,705,685
Quality Incentives	771,871	407,784	1,179,654	280,460		2,860	1,462,974
Reinsurance & Other	458,623	329,773	788,396	204,511	4,862	179,458	1,177,226
Total Medical Expenses	124,690,991	101,051,093	225,742,085	22,572,043	1,462,934	1,725,332	251,502,394
Medical Loss Ratio	92.3%	91.6%	92.0%	91.9%	86.0%	81.5%	91.9%
GROSS MARGIN	**10,439,445**	**9,245,560**	**19,685,005**	**1,983,468**	**238,160**	**391,071**	**22,297,704**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,350,469	717,406	29,554	89,178	6,186,608
Professional fees			155,152	58,557	14,666	112	228,486
Purchased services			539,539	179,407	20,782	7,115	746,843
Printing & Postage			384,396	24,095	(1,120)	14,676	422,047
Depreciation & Amortization			392,048			2,074	394,122
Other expenses			1,003,914	30,118	-	2,209	1,036,241
Indirect cost allocation & Occupancy			(218,887)	557,394	34,965	3,168	376,639
Total Administrative Expenses			7,606,630	1,566,977	98,848	118,532	9,390,986
Admin Loss Ratio			3.1%	6.4%	5.8%	5.6%	3.4%
INCOME (LOSS) FROM OPERATIONS			12,078,375	416,492	139,312	272,539	12,906,718
INVESTMENT INCOME							1,157,657
TOTAL GRANT INCOME			29,674				29,674
OTHER INCOME			295				295
CHANGE IN NET ASSETS			**$ 12,108,345**	**$ 416,492**	**$ 139,312**	**$ 272,539**	**$ 14,094,345**

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CalOptima A Public Agency Better. Together.

Consolidated Revenue & Expense: September 2018 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,566,115	713,489	2,279,604	44,217	4,149	845	2,328,815
REVENUES							
Capitation Revenue	$ 405,310,027	$ 332,992,311	$ 738,302,338	$ 78,522,966	$ 3,709,001	$ 6,243,526	$ 826,777,831
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	405,310,027	332,992,311	738,302,338	78,522,966	3,709,001	6,243,526	826,777,831
MEDICAL EXPENSES							
Provider Capitation	107,613,097	150,274,278	257,887,375	35,462,557	834,400		294,184,332
Facilities	71,031,671	69,748,142	140,779,813	9,221,116	1,554,167	1,138,148	152,693,245
Ancillary	-	-	-	1,590,648	64,404	-	1,655,052
Professional Claims	48,481,531	19,661,049	68,142,581	-	-	1,272,955	69,415,535
Prescription Drugs	51,771,338	58,696,402	110,467,740	16,244,579	1,305,642	434,783	128,452,744
MLTSS	98,274,313	8,711,593	106,985,906	4,126,357	314,907	966	111,428,136
Medical Management	6,101,954	2,831,590	8,933,544	3,233,301	166,451	1,722,535	14,055,831
Quality Incentives	2,316,106	1,217,855	3,533,960	841,480		8,450	4,383,890
Reinsurance & Other	1,625,667	766,987	2,392,654	686,415	17,862	527,609	3,624,540
Total Medical Expenses	387,215,676	311,907,896	699,123,572	71,406,453	4,257,833	5,105,446	779,893,304
Medical Loss Ratio	95.5%	93.7%	94.7%	90.9%	114.8%	81.8%	94.3%
GROSS MARGIN	**18,094,351**	**21,084,415**	**39,178,766**	**7,116,513**	**(548,833)**	**1,138,080**	**46,884,527**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			17,247,439	2,265,612	87,911	274,902	19,875,865
Professional fees			506,285	66,890	44,000	336	617,512
Purchased services			1,915,309	551,809	50,327	24,215	2,541,660
Printing & Postage			900,076	124,501	5,618	21,077	1,051,272
Depreciation & Amortization			1,197,790			6,222	1,204,012
Other expenses			3,369,143	126,120	60	(726)	3,494,596
Indirect cost allocation & Occupancy			(660,650)	1,672,182	104,895	9,402	1,125,829
Total Administrative Expenses			24,475,392	4,807,114	292,812	335,428	29,910,746
Admin Loss Ratio			3.3%	6.1%	7.9%	5.4%	3.6%
INCOME (LOSS) FROM OPERATIONS			14,703,374	2,309,399	(841,645)	802,653	16,973,781
INVESTMENT INCOME							6,620,364
OTHER INCOME			580				580
CHANGE IN NET ASSETS			**$ 14,703,953**	**$ 2,309,399**	**$ (841,645)**	**$ 802,653**	**$ 23,594,724**

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CalOptima A Public Agency Better. Together.

Balance Sheet:
As of September 2018

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$526,049,187	Accounts Payable	$37,401,847
Investments	448,077,160	Medical Claims liability	793,283,942
Capitation receivable	276,409,875	Accrued Payroll Liabilities	11,840,799
Receivables - Other	24,651,358	Deferred Revenue	86,708,180
Prepaid expenses	5,425,513	Deferred Lease Obligations	101,741
		Capitation and Withholds	114,416,290
Total Current Assets	**1,280,613,092**	**Total Current Liabilities**	**1,043,752,798**
Capital Assets			
Furniture & Equipment	34,328,849		
Building/Leasehold Improvements	8,450,614		
505 City Parkway West	49,743,943		
	92,523,406		
Less: accumulated depreciation	(42,726,533)		
Capital assets, net	49,796,873	Other (than pensions) post employment benefits liability	24,937,253
Other Assets		Net Pension Liabilities	24,978,524
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	100,000
Board-designated assets			
Cash and Cash Equivalents	9,445,741	**TOTAL LIABILITIES**	**1,093,768,575**
Long-term Investments	531,035,490		
Total Board-designated Assets	540,481,230	Deferred Inflows	
Total Other Assets	540,781,230	Change in Assumptions	3,329,380
TOTAL ASSETS	**1,871,191,196**	TNE	83,012,013
		Funds in Excess of TNE	702,214,278
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	785,226,291
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,882,324,246**	**TOTAL LIABILITIES & FUND BALANCES**	**1,882,324,246**

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CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis
As of September 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	147,932,482				
	Tier 1 - Logan Circle	147,797,556				
	Tier 1 - Wells Capital	147,252,243				
Board-designated Reserve		442,982,281	315,046,704	485,643,298	127,935,577	(42,661,016)
TNE Requirement	Tier 2 - Logan Circle	97,498,949	83,012,013	83,012,013	14,486,936	14,486,936
	Consolidated:	**540,481,230**	**398,058,718**	**568,655,311**	**142,422,513**	**(28,174,081)**
	Current reserve level	*1.90*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

September 2018

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CalOptima - Consolidated
Financial Highlights
For the Three Months Ended September 30, 2018

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
774,440	784,699	(10,259)	(1.3%)	Member Months	2,328,815	2,354,675	(25,860)	(1.1%)
273,800,098	277,026,096	(3,225,998)	(1.2%)	Revenues	826,777,831	827,714,656	(936,825)	(0.1%)
251,502,394	260,513,607	9,011,213	3.5%	Medical Expenses	779,893,304	786,968,561	7,075,257	0.9%
9,390,986	12,154,367	2,763,380	22.7%	Administrative Expenses	29,910,746	37,782,748	7,872,002	20.8%
12,906,718	**4,358,122**	**8,548,596**	**196.2%**	**Operating Margin**	**16,973,781**	**2,963,347**	**14,010,434**	**472.8%**
1,187,626	416,667	770,959	185.0%	Non Operating Income (Loss)	6,620,944	1,250,000	5,370,943	429.7%
14,094,345	**4,774,789**	**9,319,556**	**195.2%**	**Change in Net Assets**	**23,594,724**	**4,213,347**	**19,381,377**	**460.0%**
91.9%	94.0%	2.2%		Medical Loss Ratio	94.3%	95.1%	0.7%	
3.4%	4.4%	1.0%		Administrative Loss Ratio	3.6%	4.6%	0.9%	
4.7%	1.6%	3.1%		Operating Margin Ratio	2.1%	0.4%	1.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Three Months Ended September 30, 2018

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	758,098	768,201	(10,103)	(1 3%)
OneCare Connect	14,681	14,891	(210)	(1 4%)
OneCare	1,375	1,324	51	3 9%
PACE	286	283	3	1 1%
Total	774,440	784,699	(10,259)	(1 3%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 12,108	$ 4,988	$ 7,120	142 8%
OneCare Connect	416	(622)	1,039	166 9%
OneCare	139	(40)	179	447 5%
PACE	273	33	240	727 5%
505 Bldg	-	-	-	0 0%
Investment Income & Other	1,158	417	741	177 7%
Total	$ 14,094	$ 4,776	$ 9,318	195 1%

MLR

	Actual	Budget	% Point Var
Medi-Cal	92 0%	94 0%	2 0
OneCare Connect	91 9%	95 1%	3 2
OneCare	86 0%	94 4%	8 4

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,607	$ 10,020	$ 2,414	24 1%
OneCare Connect	1,567	1,834	267	14 5%
OneCare	99	129	31	23 6%
PACE	119	171	52	30 6%
Total	$ 9,391	$ 12,154	$ 2,763	22 7%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	927	1,054	127
OneCare Connect	221	234	13
OneCare	5	6	1
PACE	59	79	20
Total	1,212	1,373	161

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	817	729	89
OneCare Connect	66	64	3
OneCare	279	221	58
PACE	5	4	1
Total	1,168	1,016	151

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	2,279,604	2,305,152	(25,548)	(1 1%)
OneCare Connect	44,217	44,720	(503)	(1 1%)
OneCare	4,149	3,972	177	4 5%
PACE	845	831	14	1 7%
Total	2,328,815	2,354,675	(25,860)	(1 1%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 14,704	$ 5,931	$ 8,773	147 9%
OneCare Connect	2,309	(2,835)	5,144	181 5%
OneCare	(842)	(198)	(643)	(324 1%)
PACE	803	65	738	1129 6%
505 Bldg	-	-	-	0 0%
Investment Income & Other	6,621	1,250	5,371	429 7%
Total	$ 23,595	$ 4,213	$ 19,382	460 1%

MLR

	Actual	Budget	% Point Var
Medi-Cal	94 7%	95 0%	0 3
OneCare Connect	90 9%	96 2%	5 3
OneCare	114 8%	95 9%	(18 9)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 24,475	$ 31,246	$ 6,771	21 7%
OneCare Connect	4,807	5,665	857	15 1%
OneCare	293	396	103	26 0%
PACE	335	477	141	29 6%
Total	$ 29,911	$ 37,783	$ 7,872	20 8%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	2,783	3,118	336
OneCare Connect	659	702	43
OneCare	14	18	4
PACE	178	223	45
Total	3,634	4,061	427

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	819	739	80
OneCare Connect	67	64	3
OneCare	306	221	86
PACE	5	4	1
Total	1,197	1,027	170

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended September 30, 2018

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	774,440		784,700		(10,260)	
REVENUE						
Medi-Cal	$ 245,427,089	$ 323 74	$ 248,476,558	$ 323 45	$ (3,049,468)	$ 0 29
OneCare Connect	24,555,512	1,672 60	24,900,078	1,672 04	(344,566)	0 56
OneCare	1,701,094	1,237 16	1,600,255	1,208 65	100,839	28 51
PACE	2,116,403	7,400 01	2,049,205	7,241 01	67,198	159 00
Total Operating Revenue	273,800,098	353 55	277,026,096	353 03	(3,225,998)	0 52
MEDICAL EXPENSES						
Medi-Cal	225,742,085	297 77	233,468,419	303 92	7,726,334	6 15
OneCare Connect	22,572,043	1,537 50	23,688,789	1,590 71	1,116,746	53 21
OneCare	1,462,934	1,063 95	1,510,900	1,141 16	47,965	77 21
PACE	1,725,332	6,032 63	1,845,499	6,521 20	120,167	488 57
Total Medical Expenses	251,502,394	324 75	260,513,607	331 99	9,011,213	7 24
GROSS MARGIN	22,297,704	28 80	16,512,489	21 04	5,785,215	7 76
ADMINISTRATIVE EXPENSES						
Salaries and benefits	6,186,608	7 99	7,555,479	9 63	1,368,872	1 64
Professional fees	228,486	0 30	412,334	0 53	183,848	0 23
Purchased services	746,843	0 96	1,235,016	1 57	488,173	0 61
Printing & Postage	422,047	0 54	533,145	0 68	111,097	0 14
Depreciation & Amortization	394,122	0 51	464,167	0 59	70,045	0 08
Other expenses	1,036,241	1 34	1,581,993	2 02	545,752	0 68
Indirect cost allocation & Occupancy expense	376,639	0 49	372,234	0 47	(4,406)	(0 02)
Total Administrative Expenses	9,390,986	12 13	12,154,367	15 49	2,763,380	3 36
INCOME (LOSS) FROM OPERATIONS	12,906,718	16 67	4,358,122	5 55	8,548,596	11 12
INVESTMENT INCOME						
Interest income	2,566,654	3 31	416,667	0 53	2,149,988	2 78
Realized gain/(loss) on investments	(226,274)	(0 29)	-	-	(226,274)	(0 29)
Unrealized gain/(loss) on investments	(1,182,723)	(1 53)	-	-	(1,182,723)	(1 53)
Total Investment Income	1,157,657	1 49	416,667	0 53	740,991	0 96
NET RENTAL INCOME	-	-	-	-	-	-
TOTAL MCO TAX	(0)	-	-	-	(0)	-
TOTAL GRANT INCOME	29,674	0 04	-	-	29,674	0 04
QAF/IGT	-	-	-	-	-	-
OTHER INCOME	295	-	-	-	295	-
CHANGE IN NET ASSETS	**14,094,345**	**18.20**	**4,774,789**	**6.08**	**9,319,556**	**12.12**
MEDICAL LOSS RATIO	**91.9%**		**94.0%**		**2.2%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.4%**		**1.0%**	

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2018

	Actual		Budget		Variance	
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
MEMBER MONTHS	2,328,815		2,354,675		(25,860)	
REVENUE						
Medi-Cal	$ 738,302,338	$ 323 87	$ 742,155,159	$ 321 96	$ (3,852,821)	$ 1 91
OneCare Connect	78,522,966	1,775 85	74,781,595	1,672 22	3,741,371	103 63
OneCare	3,709,001	893 95	4,757,651	1,197 80	(1,048,651)	(303 85)
PACE	6,243,526	7,388 79	6,020,250	7,244 58	223,276	144 21
Total Operating Revenue	826,777,831	355 02	827,714,656	351 52	(936,825)	3 50
MEDICAL EXPENSES						
Medi-Cal	699,123,572	306 69	704,977,747	305 83	5,854,175	(0 86)
OneCare Connect	71,406,453	1,614 91	71,951,816	1,608 94	545,363	(5 97)
OneCare	4,257,833	1,026 23	4,560,541	1,148 17	302,708	121 94
PACE	5,105,446	6,041 95	5,478,457	6,592 61	373,011	550 66
Total Medical Expenses	779,893,304	334 89	786,968,561	334 22	7,075,257	(0 67)
GROSS MARGIN	46,884,527	20 13	40,746,094	17 30	6,138,432	2 83
ADMINISTRATIVE EXPENSES						
Salaries and benefits	19,875,865	8 53	23,986,093	10 19	4,110,228	1 66
Professional fees	617,512	0 27	1,237,000	0 53	619,488	0 26
Purchased services	2,541,660	1 09	3,707,538	1 57	1,165,878	0 48
Printing & Postage	1,051,272	0 45	1,599,436	0 68	548,164	0 23
Depreciation & Amortization	1,204,012	0 52	1,392,499	0 59	188,487	0 07
Other expenses	3,494,596	1 50	4,743,482	2 01	1,248,886	0 51
Indirect cost allocation & Occupancy expense	1,125,829	0 48	1,116,700	0 47	(9,129)	(0 01)
Total Administrative Expenses	29,910,746	12 84	37,782,748	16 05	7,872,002	3 21
INCOME (LOSS) FROM OPERATIONS	16,973,781	7 29	2,963,347	1 26	14,010,434	6 03
INVESTMENT INCOME						
Interest income	7,356,911	3 16	1,250,000	0 53	6,106,911	2 63
Realized gain/(loss) on investments	(655,074)	(0 28)	-	-	(655,074)	(0 28)
Unrealized gain/(loss) on investments	(81,472)	(0 03)	-	-	(81,472)	(0 03)
Total Investment Income	6,620,364	2 84	1,250,000	0 53	5,370,364	2 31
NET RENTAL INCOME	(0)	-	-	-	(0)	-
TOTAL MCO TAX	0	-	-	-	0	-
TOTAL GRANT INCOME	-	-	-	-	-	-
QAF/IGT	-	-	-	-	-	-
OTHER INCOME	580	-	-	-	580	-
CHANGE IN NET ASSETS	**23,594,724**	**10.13**	**4,213,347**	**1.79**	**19,381,377**	**8.34**
MEDICAL LOSS RATIO	**94.3%**		**95.1%**		**0.7%**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**4.6%**		**0.9%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended September 30, 2018

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	520,360	237,738	758,098	14,681	1,375	286	774,440
REVENUES							
Capitation Revenue	$ 135,130,436	$ 110,296,653	$ 245,427,089	$ 24,555,512	$ 1,701,094	$ 2,116,403	$ 273,800,098
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	135,130,436	110,296,653	245,427,089	24,555,512	1,701,094	2,116,403	273,800,098
MEDICAL EXPENSES							
Provider Capitation	36,001,129	50,216,249	86,217,378	11,050,443	384,233		97,652,054
Facilities	23,349,178	22,765,565	46,114,743	3,034,809	395,068	348,991	49,893,610
Ancillary	-	-	-	457,963	6,478	-	464,441
Professional Claims	13,627,334	4,965,744	18,593,078	-	-	472,748	19,065,826
Prescription Drugs	16,094,887	18,423,410	34,518,297	5,074,377	505,809	147,835	40,246,318
MLTSS	32,388,120	2,919,672	35,307,792	1,409,972	116,360	136	36,834,259
Medical Management	1,999,850	1,022,897	3,022,747	1,059,509	50,125	573,304	4,705,685
Quality Incentives	771,871	407,784	1,179,654	280,460		2,860	1,462,974
Reinsurance & Other	458,623	329,773	788,396	204,511	4,862	179,458	1,177,226
Total Medical Expenses	124,690,991	101,051,093	225,742,085	22,572,043	1,462,934	1,725,332	251,502,394
Medical Loss Ratio	92 3%	91 6%	92 0%	91 9%	86 0%	81 5%	91 9%
GROSS MARGIN	**10,439,445**	**9,245,560**	**19,685,005**	**1,983,468**	**238,160**	**391,071**	**22,297,704**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,350,469	717,406	29,554	89,178	6,186,608
Professional fees			155,152	58,557	14,666	112	228,486
Purchased services			539,539	179,407	20,782	7,115	746,843
Printing & Postage			384,396	24,095	(1,120)	14,676	422,047
Depreciation & Amortization			392,048			2,074	394,122
Other expenses			1,003,914	30,118	-	2,209	1,036,241
Indirect cost allocation & Occupancy			(218,887)	557,394	34,965	3,168	376,639
Total Administrative Expenses			7,606,630	1,566,977	98,848	118,532	9,390,986
Admin Loss Ratio			3 1%	6 4%	5 8%	5 6%	3 4%
INCOME (LOSS) FROM OPERATIONS			12,078,375	416,492	139,312	272,539	12,906,718
INVESTMENT INCOME							1,157,657
NET RENTAL INCOME							-
TOTAL MCO TAX							(0)
TOTAL GRANT INCOME			29,674				29,674
QAF/IGT							-
OTHER INCOME			295				295
CHANGE IN NET ASSETS			**$ 12,108,345**	**$ 416,492**	**$ 139,312**	**$ 272,539**	**$ 14,094,345**
BUDGETED CHANGE IN NET ASSETS			4,987,664	(622,384)	(40,091)	32,934	4,774,789
VARIANCE TO BUDGET - FAV (UNFAV)			$ 7,120,681	$ 1,038,876	$ 179,404	$ 239,605	$ 9,319,556

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Three Months Ended September 30, 2018

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,566,115	713,489	2,279,604	44,217	4,149	845	2,328,815
REVENUES							
Capitation Revenue	$ 405,310,027	$ 332,992,311	$ 738,302,338	$ 78,522,966	$ 3,709,001	$ 6,243,526	$ 826,777,831
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	405,310,027	332,992,311	738,302,338	78,522,966	3,709,001	6,243,526	826,777,831
MEDICAL EXPENSES							
Provider Capitation	107,613,097	150,274,278	257,887,375	35,462,557	834,400		294,184,332
Facilities	71,031,671	69,748,142	140,779,813	9,221,116	1,554,167	1,138,148	152,693,245
Ancillary	-	-	-	1,590,648	64,404	-	1,655,052
Professional Claims	48,481,531	19,661,049	68,142,581	-	-	1,272,955	69,415,535
Prescription Drugs	51,771,338	58,696,402	110,467,740	16,244,579	1,305,642	434,783	128,452,744
MLTSS	98,274,313	8,711,593	106,985,906	4,126,357	314,907	966	111,428,136
Medical Management	6,101,954	2,831,590	8,933,544	3,233,301	166,451	1,722,535	14,055,831
Quality Incentives	2,316,106	1,217,855	3,533,960	841,480		8,450	4,383,890
Reinsurance & Other	1,625,667	766,987	2,392,654	686,415	17,862	527,609	3,624,540
Total Medical Expenses	387,215,676	311,907,896	699,123,572	71,406,453	4,257,833	5,105,446	779,893,304
Medical Loss Ratio	95 5%	93 7%	94 7%	90 9%	114 8%	81 8%	94 3%
GROSS MARGIN	**18,094,351**	**21,084,415**	**39,178,766**	**7,116,513**	**(548,833)**	**1,138,080**	**46,884,527**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			17,247,439	2,265,612	87,911	274,902	19,875,865
Professional fees			506,285	66,890	44,000	336	617,512
Purchased services			1,915,309	551,809	50,327	24,215	2,541,660
Printing & Postage			900,076	124,501	5,618	21,077	1,051,272
Depreciation & Amortization			1,197,790			6,222	1,204,012
Other expenses			3,369,143	126,120	60	(726)	3,494,596
Indirect cost allocation & Occupancy			(660,650)	1,672,182	104,895	9,402	1,125,829
Total Administrative Expenses			24,475,392	4,807,114	292,812	335,428	29,910,746
Admin Loss Ratio			3 3%	6 1%	7 9%	5 4%	3 6%
INCOME (LOSS) FROM OPERATIONS			14,703,374	2,309,399	(841,645)	802,653	16,973,781
INVESTMENT INCOME							6,620,364
NET RENTAL INCOME							(0)
TOTAL MCO TAX							0
TOTAL GRANT INCOME			-				-
QAF/IGT							-
OTHER INCOME			580				580
CHANGE IN NET ASSETS			**$ 14,703,953**	**$ 2,309,399**	**$ (841,645)**	**$ 802,653**	**$ 23,594,724**
BUDGETED CHANGE IN NET ASSETS			5,931,317	(2,834,775)	(198,471)	65,275	4,213,347
VARIANCE TO BUDGET - FAV (UNFAV)			$ 8,772,636	$ 5,144,174	$ (643,173)	$ 737,377	$ 19,381,377

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SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $14.1 million, $9.3 million favorable to budget
- Operating surplus is $12.9 million with a surplus in non-operating of $1.2 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $23.6 million, $19.4 million favorable to budget
- Operating surplus is $17.0 million, with a surplus in non-operating of $6.6 million

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
12.1	5.0	7.1	Medi-Cal	14.7	5.9	8.8
0.4	(0.6)	1.0	OCC	2.3	(2.8)	5.1
0.1	(0.0)	0.2	OneCare	(0.8)	(0.2)	(0.6)
0.3	0.0	0.2	PACE	0.8	0.1	0.7
12.9	**4.4**	**8.6**	**Operating**	**17.0**	**3.0**	**14.0**
1.2	0.4	0.7	Inv./Rental Inc, MCO tax	6.6	1.3	5.4
1.2	**0.4**	**0.7**	**Non-Operating**	**6.6**	**1.3**	**5.4**
14.1	**4.8**	**9.3**	**TOTAL**	**23.6**	**4.2**	**19.4**

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CalOptima
Enrollment Summary
For the Three Months Ended September 30, 2018

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
63,892	64,219	(327)	(0.5%)	Aged	191,296	191,985	(689)	(0.4%)
620	620	-	0.0%	BCCTP	1,862	1,860	2	0.1%
46,863	47,122	(259)	(0.5%)	Disabled	141,101	141,339	(238)	(0.2%)
311,532	315,672	(4,140)	(1.3%)	TANF Child	938,815	948,571	(9,756)	(1.0%)
94,075	95,129	(1,054)	(1.1%)	TANF Adult	282,899	286,425	(3,526)	(1.2%)
3,378	3,471	(93)	(2.7%)	LTC	10,142	10,380	(238)	(2.3%)
237,738	241,968	(4,230)	(1.7%)	MCE	713,489	724,592	(11,103)	(1.5%)
758,098	**768,201**	**(10,103)**	**(1.3%)**	**Medi-Cal**	**2,279,604**	**2,305,152**	**(25,548)**	**(1.1%)**
14,681	**14,891**	**(210)**	**(1.4%)**	**OneCare Connect**	**44,217**	**44,720**	**(503)**	**(1.1%)**
286	**283**	**3**	**1.1%**	**PACE**	**845**	**831**	**14**	**1.7%**
1,375	**1,324**	**51**	**3.9%**	**OneCare**	**4,149**	**3,972**	**177**	**4.5%**
774,440	**784,699**	**(10,259)**	**(1.3%)**	**CalOptima Total**	**2,328,815**	**2,354,675**	**(25,860)**	**(1.1%)**

				Enrollment (By Network)				
167,119	168,158	(1,039)	(0.6%)	HMO	501,115	505,016	(3,901)	(0.8%)
218,315	222,237	(3,922)	(1.8%)	PHC	653,398	666,905	(13,507)	(2.0%)
192,897	192,537	360	0.2%	Shared Risk Group	578,474	580,030	(1,556)	(0.3%)
179,767	185,269	(5,502)	(3.0%)	Fee for Service	546,617	553,201	(6,584)	(1.2%)
758,098	**768,201**	**(10,103)**	**(1.3%)**	**Medi-Cal**	**2,279,604**	**2,305,152**	**(25,548)**	**(1.1%)**
14,681	**14,891**	**(210)**	**(1.4%)**	**OneCare Connect**	**44,217**	**44,720**	**(503)**	**(1.1%)**
286	**283**	**3**	**1.1%**	**PACE**	**845**	**831**	**14**	**1.7%**
1,375	**1,324**	**51**	**3.9%**	**OneCare**	**4,149**	**3,972**	**177**	**4.5%**
774,440	**784,699**	**(10,259)**	**(1.3%)**	**CalOptima Total**	**2,328,815**	**2,354,675**	**(25,860)**	**(1.1%)**

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CalOptima
Enrollment Trend by Network Type
Fiscal Year 2019

Network Type	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	MMs
HMO													
Aged	3,844	3,866	3,841										11,551
BCCTP	1	1	1										3
Disabled	6,744	6,789	6,789										20,322
TANF Child	58,435	58,267	58,162										174,864
TANF Adult	29,473	29,373	29,404										88,250
LTC	2	2	3										7
MCE	68,597	68,602	68,919										206,118
	167,096	166,900	167,119										501,115
PHC													
Aged	1,600	1,621	1,620										4,841
BCCTP	-	-	-										-
Disabled	7,243	7,239	7,230										21,712
TANF Child	157,157	156,755	157,444										471,356
TANF Adult	12,731	12,684	12,787										38,202
LTC	-	1	-										1
MCE	39,060	38,992	39,234										117,286
	217,791	217,292	218,315										653,398
Shared Risk Group													
Aged	3,593	3,605	3,621										10,819
BCCTP	-	-	-										-
Disabled	7,626	7,554	7,486										22,666
TANF Child	67,471	67,226	67,159										201,856
TANF Adult	30,936	30,567	30,622										92,125
LTC	2	-	1										3
MCE	83 554	83 443	84 008										251 005
	193 182	192 395	192 897										578 474
Fee for Service (Dual)													
Aged	49,903	50,943	50,657										151,503
BCCTP	16	15	18										49
Disabled	20,706	20,863	20,741										62,310
TANF Child	2	3	2										7
TANF Adult	1,081	1,083	1,064										3,228
LTC	3,025	3,019	3,007										9,051
MCE	2,327	2,367	2,416										7,110
	77,060	78,293	77,905										233,258
Fee for Service (Non-Dual)													
Aged	4,702	3,727	4,153										12,582
BCCTP	613	596	601										1,810
Disabled	4,802	4,672	4,617										14,091
TANF Child	30,166	31,801	28,765										90,732
TANF Adult	20,308	20,588	20,198										61,094
LTC	353	360	367										1,080
MCE	44,399	44,410	43,161										131,970
	105,343	106,154	101,862										313,359
MEDI-CAL TOTAL													
Aged	63,642	63,762	63,892										191,296
BCCTP	630	612	620										1,862
Disabled	47,121	47,117	46,863										141,101
TANF Child	313,231	314,052	311,532										938,815
TANF Adult	94,529	94,295	94,075										282,899
LTC	3,382	3,382	3,378										10,142
MCE	237 937	237 814	237 738										713 489
	760,472	761,034	758,098										2,279,604
PACE	273	286	286										845
OneCare	1,390	1,384	1,375										4,149
OneCare Connect	16,399	13,137	14,681										44,217
TOTAL	778,534	775,841	774,440										2,328,815

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ENROLLMENT:

Overall September enrollment was 774,440

- Unfavorable to budget 10,259 or 1.3%
- Decreased 1,401 or 0.2% from prior month (August 2018)
- Decreased 21,741 or 2.7% from prior year (September 2017)

Medi-Cal enrollment was 758,098

- Unfavorable to budget 10,103
    - Temporary Assistance for Needy Families (TANF) unfavorable 5,194
    - Medi-Cal Expansion (MCE) unfavorable 4,230
    - Senior Persons with Disabilities (SPD) unfavorable 586
    - Long-Term Care (LTC) unfavorable 93
- Decreased 2,936 from prior month

OneCare Connect enrollment was 14,681

- Unfavorable to budget 210
- Increased 1,544 from prior month due to adjustments to prior year (PY) enrollment

OneCare enrollment was 1,375

- Favorable to budget 51
- Decreased 9 from prior month

PACE enrollment was 286

- Favorable to budget 3
- No change from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
758,098	**768,201**	**(10,103)**	**(1.3%)**	**Member Months**	**2,279,604**	**2,305,152**	**(25,548)**	**(1.1%)**
				Revenues				
245,427,089	248,476,558	(3,049,468)	(1 2%)	Capitation revenue	738,302,338	742,155,159	(3,852,821)	(0 5%)
-	-	-	0 0%	Other income	-	-	-	0 0%
245,427,089	**248,476,558**	**(3,049,468)**	**(1.2%)**	**Total Operating Revenue**	**738,302,338**	**742,155,159**	**(3,852,821)**	**(0.5%)**
				Medical Expenses				
87,397,032	84,492,271	(2,904,762)	(3 4%)	Provider capitation	261,421,335	253,407,431	(8,013,904)	(3 2%)
46,114,743	43,012,174	(3,102,568)	(7 2%)	Facilities	140,779,813	130,678,836	(10,100,977)	(7 7%)
18,593,078	28,228,162	9,635,084	34 1%	Professional Claims	68,142,581	83,376,603	15,234,023	18 3%
34,518,297	38,196,935	3,678,638	9 6%	Prescription drugs	110,467,740	116,400,704	5,932,965	5 1%
35,307,792	35,605,853	298,061	0 8%	MLTSS	106,985,906	108,784,874	1,798,968	1 7%
3,022,747	3,402,390	379,643	11 2%	Medical management	8,933,544	10,737,397	1,803,852	16 8%
788,396	530,634	(257,762)	(48 6%)	Reinsurance & other	2,392,654	1,591,902	(800,752)	(50 3%)
225,742,085	**233,468,419**	**7,726,334**	**3.3%**	**Total Medical Expenses**	**699,123,572**	**704,977,747**	**5,854,175**	**0.8%**
19,685,005	**15,008,139**	**4,676,866**	**31.2%**	**Gross Margin**	**39,178,766**	**37,177,412**	**2,001,354**	**5.4%**
				Administrative Expenses				
5,350,469	6,569,668	1,219,199	18 6%	Salaries, wages & employee benefits	17,247,439	20,893,680	3,646,240	17 5%
155,152	349,651	194,499	55 6%	Professional fees	506,285	1,048,950	542,665	51 7%
539,539	945,149	405,610	42 9%	Purchased services	1,915,309	2,837,938	922,629	32 5%
384,396	423,309	38,913	9 2%	Printing and postage	900,076	1,269,928	369,852	29 1%
392,048	462,076	70,028	15 2%	Depreciation and amortization	1,197,790	1,386,227	188,437	13 6%
1,003,914	1,494,214	490,300	32 8%	Other operating expenses	3,369,143	4,480,146	1,111,004	24 8%
(218,887)	(223,591)	(4,704)	(2 1%)	Indirect cost allocation, Occupancy Expense	(660,650)	(670,774)	(10,124)	(1 5%)
7,606,630	**10,020,475**	**2,413,845**	**24.1%**	**Total Administrative Expenses**	**24,475,392**	**31,246,095**	**6,770,703**	**21.7%**
				Operating Tax				
10,636,084	10,777,853	(141,769)	(1 3%)	Tax Revenue	31,982,897	32,341,282	(358,385)	(1 1%)
10,636,084	10,777,853	141,769	1 3%	Premium tax expense	31,982,897	21,557,144	(10,425,753)	(48 4%)
-	-	-	0 0%	Sales tax expense	-	10,784,138	10,784,138	100 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
66,301	249,874	(183,573)	(73 5%)	Grant Revenue	198,032	749,622	(551,590)	(73 6%)
47,813	223,107	175,295	78 6%	Grant expense - Service Partner	142,800	669,321	526,521	78 7%
(11,186)	26,767	37,953	141 8%	Grant expense - Administrative	55,232	80,301	25,069	31 2%
29,674	-	29,674	**0.0%**	**Total Grant Income**	-	-	-	**0.0%**
-	**-**	**-**	**0.0%**	**QAF and IGT - Net**	**0**	**-**	**0**	**0.0%**
295	**-**	**295**	**0.0%**	**Other income**	**580**	**-**	**580**	**0.0%**
295	-	295	0 0%	MC Other income	580	-	580	0 0%
12,108,345	**4,987,664**	**7,120,681**	**142.8%**	**Change in Net Assets**	**14,703,953**	**5,931,317**	**8,772,636**	**147.9%**
92.0%	***94.0%***	***2.0%***	***2.1%***	***Medical Loss Ratio***	***94.7%***	***95.0%***	***0.3%***	***0.3%***
3.1%	***4.0%***	***0.9%***	***23.1%***	***Admin Loss Ratio***	***3.3%***	***4.2%***	***0.9%***	***21.3%***

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MEDI-CAL INCOME STATEMENT – SEPTEMBER MONTH:

REVENUES of $245.4 million are unfavorable to budget $3.0 million, driven by:

- Unfavorable volume related variance of $3.3 million
- Favorable price related variance of $0.2 million

MEDICAL EXPENSES are $225.7 million, favorable to budget $7.7 million due to:

- **Professional Claims** expense is favorable to budget $9.6 million due to Child Health and Disability Prevention Program (CHDP) expenses of $2.0 million, BHT expenses of $2.0 million, Proposition 56 expenses of $2.6 million and Incurred But Not Reported (IBNR) expenses of $1.1 million. Actual CHDP and Proposition 56 expenses reported in Provider Capitation
- **Prescription Drug** expense is favorable to budget $3.7 million
- **Facilities** expense is unfavorable to budget $3.1 million due to outpatient claims totaling $2.1 million and inpatient claims totaling $0.6 million
- **Provider Capitation** expense is unfavorable to budget $2.9 million due to CHDP and Proposition 56 capitation expense of $2.0 million that were budgeted in Professional Claims
- **Managed Long Term Services and Supports (MLTSS)** expense is favorable to budget $0.3 million

ADMINISTRATIVE EXPENSES are $7.6 million, favorable to budget $2.4 million, driven by:

- **Salary & Benefits**: $1.2 million favorable to budget from open positions
- **Purchased Services**: $0.4 million favorable to budget
- **Other Non-Salary**: $0.8 million favorable to budget

CHANGE IN NET ASSETS is $12.1 million for the month, $7.1 million favorable to budget

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Three Months Ended September 30, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,681	**14,891**	**(210)**	**(1.4%)**	**Member Months**	**44,217**	**44,720**	**(503)**	**(1.1%)**
				Revenues				
2,675,363	3,325,465	(650,102)	(19 5%)	Medi-Cal Capitation revenue	7,915,788	10,058,392	(2,142,604)	(21 3%)
16,825,562	16,880,288	(54,726)	(0 3%)	Medicare Capitation revenue part C	52,391,843	50,624,458	1,767,385	3 5%
5,054,587	4,694,325	360,262	7 7%	Medicare Capitation revenue part D	18,215,334	14,098,745	4,116,589	29 2%
-	-	-	0 0%	Other Income	-	-	-	0 0%
24,555,512	**24,900,078**	**(344,566)**	**(1.4%)**	**Total Operating Revenue**	**78,522,966**	**74,781,595**	**3,741,371**	**5.0%**
				Medical Expenses				
11,330,903	11,315,021	(15,882)	(0 1%)	Provider capitation	36,304,037	33,940,101	(2,363,936)	(7 0%)
3,034,809	3,537,994	503,185	14 2%	Facilities	9,221,116	10,737,761	1,516,645	14 1%
457,963	635,949	177,986	28 0%	Ancillary	1,590,648	1,939,893	349,245	18 0%
1,409,972	1,645,953	235,981	14 3%	Long Term Care	4,126,357	5,102,422	976,065	19 1%
5,074,377	5,180,974	106,597	2 1%	Prescription drugs	16,244,579	15,874,247	(370,332)	(2 3%)
1,059,509	1,218,719	159,210	13 1%	Medical management	3,233,301	3,905,706	672,405	17 2%
204,511	154,179	(50,332)	(32 6%)	Other medical expenses	686,415	451,686	(234,729)	(52 0%)
22,572,043	**23,688,789**	**1,116,746**	**4.7%**	**Total Medical Expenses**	**71,406,453**	**71,951,816**	**545,363**	**0.8%**
1,983,468	**1,211,289**	**772,179**	**63.7%**	**Gross Margin**	**7,116,513**	**2,829,779**	**4,286,734**	**151.5%**
				Administrative Expenses				
717,406	818,709	101,303	12 4%	Salaries, wages & employee benefits	2,265,612	2,619,662	354,050	13 5%
58,557	42,917	(15,640)	(36 4%)	Professional fees	66,890	128,750	61,860	48 0%
179,407	251,415	72,009	28 6%	Purchased services	551,809	754,245	202,437	26 8%
24,095	86,202	62,106	72 0%	Printing and postage	124,501	258,605	134,104	51 9%
-	-	-	0 0%	Depreciation & amortization	-	-	-	0 0%
30,118	77,037	46,918	60 9%	Other operating expenses	126,120	231,110	104,990	45 4%
557,394	557,394	-	0 0%	Indirect cost allocation	1,672,182	1,672,182	-	0 0%
1,566,977	**1,833,673**	**266,697**	**14.5%**	**Total Administrative Expenses**	**4,807,114**	**5,664,554**	**857,440**	**15.1%**
				Operating Tax				
-	-	-	0 0%	Tax Revenue	-	-	-	0 0%
-	-	-	0 0%	Premium tax expense	-	-	-	0 0%
-	-	-	0 0%	Sales tax expense	-	-	-	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
416,492	**(622,384)**	**1,038,876**	**166.9%**	**Change in Net Assets**	**2,309,399**	**(2,834,775)**	**5,144,174**	**181.5%**
91.9%	***95.1%***	***3.2%***	***3.4%***	***Medical Loss Ratio***	***90.9%***	***96.2%***	***5.3%***	***5.5%***
6.4%	***7.4%***	***1.0%***	***13.3%***	***Admin Loss Ratio***	***6.1%***	***7.6%***	***1.5%***	***19.2%***

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ONECARE CONNECT INCOME STATEMENT – SEPTEMBER MONTH:

REVENUES of $24.6 million are unfavorable to budget $0.3 million due to volume and member mix

MEDICAL EXPENSES of $22.6 million are favorable to budget $1.1 million due to volume and IBNR

ADMINISTRATIVE EXPENSES of $1.6 million are favorable to budget $0.3 million

CHANGE IN NET ASSETS is $0.4 million, $1.0 million favorable to budget

CalOptima
OneCare
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,375	**1,324**	**51**	**3.9%**	**Member Months**	**4,149**	**3,972**	**177**	**4.5%**
				Revenues				
1,166,356	1,111,243	55,113	5 0%	Medicare Part C revenue	2,138,789	3,265,276	(1,126,486)	(34 5%)
534,739	489,012	45,726	9 4%	Medicare Part D revenue	1,570,211	1,492,376	77,836	5 2%
1,701,094	**1,600,255**	**100,839**	**6.3%**	**Total Operating Revenue**	**3,709,001**	**4,757,651**	**(1,048,651)**	**(22.0%)**
				Medical Expenses				
384,233	455,700	71,467	15 7%	Provider capitation	834,400	1,340,622	506,222	37 8%
395,068	504,048	108,980	21 6%	Inpatient	1,554,167	1,534,324	(19,842)	(1 3%)
6,478	54,025	47,547	88 0%	Ancillary	64,404	163,561	99,157	60 6%
116,360	25,991	(90,369)	(347 7%)	Skilled nursing facilities	314,907	79,706	(235,201)	(295 1%)
505,809	431,189	(74,620)	(17 3%)	Prescription drugs	1,305,642	1,320,252	14,610	1 1%
50,125	33,384	(16,740)	(50 1%)	Medical management	166,451	102,395	(64,056)	(62 6%)
4,862	6,563	1,701	25 9%	Other medical expenses	17,862	19,681	1,819	9 2%
1,462,934	**1,510,900**	**47,965**	**3.2%**	**Total Medical Expenses**	**4,257,833**	**4,560,541**	**302,708**	**6.6%**
238,160	**89,355**	**148,805**	**166.5%**	**Gross Margin**	**(548,833)**	**197,110**	**(745,943)**	**(378.4%)**
				Administrative Expenses				
29,554	37,367	7,813	20 9%	Salaries, wages & employee benefits	87,911	119,344	31,432	26 3%
14,666	19,600	4,934	25 2%	Professional fees	44,000	58,800	14,800	25 2%
20,782	17,425	(3,357)	(19 3%)	Purchased services	50,327	52,275	1,948	3 7%
(1,120)	13,206	14,326	108 5%	Printing and postage	5,618	39,618	34,000	85 8%
-	6,883	6,883	100 0%	Other operating expenses	60	20,650	20,590	99 7%
34,965	34,965	-	0 0%	Indirect cost allocation, occupancy expens	104,895	104,895	-	0 0%
98,848	**129,447**	**30,599**	**23.6%**	**Total Administrative Expenses**	**292,812**	**395,581**	**102,769**	**26.0%**
139,312	**(40,091)**	**179,404**	**447.5%**	**Change in Net Assets**	**(841,645)**	**(198,471)**	**(643,173)**	**(324.1%)**
86.0%	***94.4%***	***8.4%***	***8.9%***	***Medical Loss Ratio***	***114.8%***	***95.9%***	***(18.9%)***	***(19.8%)***
5.8%	***8.1%***	***2.3%***	***28.2%***	***Admin Loss Ratio***	***7.9%***	***8.3%***	***0.4%***	***5.1%***

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CalOptima
PACE
Statement of Revenues and Expenses
For the Three Months Ended September, 30, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
286	**283**	**3**	**1.1%**	**Member Months**	**845**	**831**	**14**	**1.7%**
				Revenues				
1,593,914	1,582,731	11,183	0 7%	Medi-Cal capitation revenue	4,705,749	4,651,670	54,079	1 2%
393,058	375,266	17,792	4 7%	Medicare Part C revenue	1,189,918	1,101,607	88,311	8 0%
129,431	91,208	38,223	41 9%	Medicare Part D revenue	347,859	266,973	80,886	30 3%
2,116,403	**2,049,205**	**67,198**	**3.3%**	**Total Operating Revenue**	**6,243,526**	**6,020,250**	**223,276**	**3.7%**
				Medical Expenses				
573,304	666,869	93,565	14 0%	Medical Management	1,722,535	2,033,248	310,713	15 3%
348,991	423,337	74,346	17 6%	Claims payments to hospitals	1,138,148	1,235,194	97,046	7 9%
472,748	452,988	(19,760)	(4 4%)	Professional claims	1,272,955	1,327,229	54,274	4 1%
179,458	126,158	(53,300)	(42 2%)	Patient transportation	527,609	370,451	(157,158)	(42 4%)
147,835	163,301	15,466	9 5%	Prescription drugs	434,783	477,928	43,145	9 0%
136	10,046	9,910	98 6%	MLTSS	966	26,157	25,191	96 3%
2,860	2,800	(60)	(2 1%)	Other Expenses	8,450	8,250	(200)	(2 4%)
1,725,332	**1,845,499**	**120,167**	**6.5%**	**Total Medical Expenses**	**5,105,446**	**5,478,457**	**373,011**	**6.8%**
391,071	**203,706**	**187,365**	**92.0%**	**Gross Margin**	**1,138,080**	**541,793**	**596,287**	**110.1%**
				Administrative Expenses				
89,178	129,735	40,557	31 3%	Salaries, wages & employee benefits	274,902	353,408	78,506	22 2%
112	167	55	32 8%	Professional fees	336	500	164	32 8%
7,115	21,027	13,911	66 2%	Purchased services	24,215	63,080	38,865	61 6%
14,676	10,428	(4,248)	(40 7%)	Printing and postage	21,077	31,285	10,208	32 6%
2,074	2,091	17	0 8%	Depreciation & amortization	6,222	6,272	50	0 8%
2,209	3,859	1,650	42 8%	Other operating expenses	(726)	11,576	12,302	106 3%
3,168	3,466	298	8 6%	Indirect cost allocation, Occupancy Expense	9,402	10,397	995	9 6%
118,532	**170,772**	**52,240**	**30.6%**	**Total Administrative Expenses**	**335,428**	**476,518**	**141,090**	**29.6%**
				Operating Tax				
3,993	-	3,993	0 0%	Tax Revenue	11,796	-	11,796	0 0%
3,993	-	(3,993)	0 0%	Premium tax expense	11,796	-	(11,796)	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
272,539	**32,934**	**239,605**	**727.5%**	**Change in Net Assets**	**802,653**	**65,275**	**737,377**	**1129.6%**
81.5%	***90.1%***	***8.5%***	***9.5%***	***Medical Loss Ratio***	***81.8%***	***91.0%***	***9.2%***	***10.1%***
5.6%	***8.3%***	***2.7%***	***32.8%***	***Admin Loss Ratio***	***5.4%***	***7.9%***	***2.5%***	***32.1%***

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CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	Rental Income	0	0	0	0.0%
0	**0**	**0**	**0.0%**	**Total Operating Revenue**	**0**	**0**	**0**	**0.0%**
				Administrative Expenses				
42,951	22,982	(19,969)	(86.9%)	Purchase services	103,898	68,945	(34,953)	(50.7%)
161,022	162,935	1,913	1.2%	Depreciation & amortization	483,460	488,804	5,344	1.1%
15,816	15,916	100	0.6%	Insurance expense	47,447	47,750	303	0.6%
91,012	173,136	82,124	47.4%	Repair and maintenance	291,467	519,408	227,941	43.9%
70,697	1,635	(69,062)	(4224.0%)	Other Operating Expense	221,476	4,905	(216,571)	(4415.3%)
(381,499)	(376,604)	4,895	1.3%	Indirect allocation, Occupancy	(1,147,748)	(1,129,812)	17,936	1.6%
0	**0**	**0**	**0.0%**	**Total Administrative Expenses**	**0**	**0**	**0**	**0.0%**
0	**0**	**0**	**0.0%**	**Change in Net Assets**	**0**	**0**	**0**	**0.0%**

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OTHER STATEMENTS – SEPTEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $139.3 thousand, $179.4 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $272.5 thousand, $239.6 thousand favorable to budget

CalOptima
Balance Sheet
September 30, 2018

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$526,049,187	Accounts Payable	$37,401,847
Investments	448,077,160	Medical Claims liability	793,283,942
Capitation receivable	276,409,875	Accrued Payroll Liabilities	11,840,799
Receivables - Other	24,651,358	Deferred Revenue	86,708,180
Prepaid expenses	5,425,513	Deferred Lease Obligations	101,741
		Capitation and Withholds	114,416,290
Total Current Assets	**1,280,613,092**	**Total Current Liabilities**	**1,043,752,798**
Capital Assets			
Furniture & Equipment	34,328,849		
Building/Leasehold Improvements	8,450,614		
505 City Parkway West	49,743,943		
	92,523,406		
Less: accumulated depreciation	(42,726,533)		
Capital assets, net	49,796,873	Other (than pensions) post employment benefits liability	24,937,253
Other Assets		Net Pension Liabilities	24,978,524
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	100,000
Board-designated assets			
Cash and Cash Equivalents	9,445,741	**TOTAL LIABILITIES**	**1,093,768,575**
Long-term Investments	531,035,490		
Total Board-designated Assets	540,481,230	Deferred Inflows	
Total Other Assets	540,781,230	Change in Assumptions	3,329,380
TOTAL ASSETS	**1,871,191,196**	TNE	83,012,013
		Funds in Excess of TNE	702,214,278
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	785,226,291
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,882,324,246**	**TOTAL LIABILITIES & FUND BALANCES**	**1,882,324,246**

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CalOptima
Board Designated Reserve and TNE Analysis
as of September 30, 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	147,932,482				
	Tier 1 - Logan Circle	147,797,556				
	Tier 1 - Wells Capital	147,252,243				
Board-designated Reserve		442,982,281	315,046,704	485,643,298	127,935,577	(42,661,016)
TNE Requirement	Tier 2 - Logan Circle	97,498,949	83,012,013	83,012,013	14,486,936	14,486,936
	Consolidated:	**540,481,230**	**398,058,718**	**568,655,311**	**142,422,513**	**(28,174,081)**
	Current reserve level	*1.90*	*1.40*	*2.00*		

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CalOptima

Statement of Cash Flows
September 30, 2018

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	14,094,345	23,594,724
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	557,057	1,687,472
Changes in assets and liabilities:		
Prepaid expenses and other	1,043,960	871,834
Catastrophic reserves		
Capitation receivable	71,535,638	20,089,784
Medical claims liability	(5,161,083)	(39,335,671)
Deferred revenue	(22,310,607)	(26,994,769)
Payable to providers	4,531,535	17,967,398
Accounts payable	9,779,976	30,585,554
Other accrued liabilities	112,200	230,881
Net cash provided by/(used in) operating activities	74,183,020	28,697,206
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(63,286,724)	132,221,788
Change in Property and Equipment	(186,663)	(726,096)
Change in Board designated reserves	212,857	(2,233,558)
Net cash provided by/(used in) investing activities	(63,260,530)	129,262,134
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	10,922,490	157,959,340
CASH AND CASH EQUIVALENTS, beginning of period	515,126,697	368,089,847
CASH AND CASH EQUIVALENTS, end of period	**526,049,187**	**526,049,187**

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BALANCE SHEET:

ASSETS increased $1.0 million from August or 0.1%

- **Operating Cash** increased by $10.9 million or 2.1% driven by month-end cut off and variable cash requirements
- **Investments** increased $63.3 million due to the Department of Health Care Services (DHCS) return of $66.0 million for Medi-Cal Expansion that they reclaimed on the July check, as this had previously been paid in full by CalOptima in May 2018
- **Net Capitation Receivables** decreased $72.9 million related to DHCS's return of funds mentioned in Investments above

LIABILITIES decreased $13.0 million from August or 1.2%

- **Medical Claims Liability** by line of business decreased $5.2 million due to reduction of DHCS overpayment
- **Deferred Revenue** decreased $22.3 million due to timing of capitation payment
- **Capitation Payable** increased $4.5 million due to increase in Risk Sharing reserve
- **Accounts Payable** increased $10.1 million due to timing of sales tax reserve and payment

NET ASSETS are $785.2 million, an increase of $14.1 million from August

CalOptima Foundation
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2018
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	**Total Operating Revenue**	0	0	0	0.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	18,553	18,553	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	8,954	8,954	100.0%
0	0	0	0.0%	Travel	0	0	0	0.0%
0	0	0	0.0%	Supplies	0	0	0	0.0%
0	0	0	0.0%	Contractual	0	0	0	0.0%
916	229,840	228,924	99.6%	Other	2,750	689,519	686,769	99.6%
916	239,009	238,093	99.6%	**Total Operating Expenditures**	2,750	717,026	714,276	99.6%
305	0	(305)	0.0%	**Investment Income**	305	0	(305)	0.0%
(611)	**(239,009)**	**(238,398)**	**(99.7%)**	**Program Income**	**(2,445)**	**(717,026)**	**(714,582)**	**(99.7%)**

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CalOptima Foundation
Balance Sheet
September 30, 2018

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,843,445	Accounts payable-Current	2,750
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,843,445**	Grants-Foundation	0
		Total Current Liabilities	**2,750**
		Total Liabilities	**2,750**
		Net Assets	**2,840,695**
TOTAL ASSETS	**2,843,445**	**TOTAL LIABILITIES & NET ASSETS**	**2,843,445**

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CALOPTIMA FOUNDATION - SEPTEMBER MONTH

INCOME STATEMENT:

OPERATING REVENUE

- No activity

OPERATING EXPENSES

- Audit Fees $0.9 thousand, $2.8 thousand year to date (YTD)

BALANCE SHEET:

ASSETS

- Cash of $2.8 million remains from the fiscal year (FY) 2014 $3.0 million transferred by CalOptima for grants and programs in support of providers and community

LIABILITIES

- $2.8 thousand for audit fees

NET INCOME is ($2.4) thousand YTD

Budget Allocation Changes
Reporting Changes for September 2018

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year

No Activity for September

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

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Board of Directors Meeting
November 1, 2018

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. OneCare Connect

- Performance Measure Validation (PMV) Audit for Medicare-Medicaid Plans (MMPs):

  On May 21, 2018, CMS notified MMPs of upcoming efforts to validate that MMPs' reported data on performance measures are reliable, valid, complete, and comparable. The following elements will be validated for the 2017 measurement year for select core and state-specific performance measures:

  - MMP Core 2.1: Members with an assessment completed within 90 days of enrollment.
  - MMP CA 1.2: High-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).
  - MMP CA 1.4: Low-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).

  On September 17, 2018, validation activities with CMS' auditors were conducted on enrollment and eligibility data processes, assessment and care plan completion processes, performance measure production and reporting, and primary source verification of selected case samples for each of the three performance measures. On September 19, 2018, CalOptima completed a response to several document requests following the PMV webinar. CalOptima anticipates the release of the preliminary findings in December 2018.

- 2018 Data Integrity Testing (*applicable to OneCare Connect and OneCare*):

  As part of its audit readiness efforts, CalOptima has engaged an independent auditing consultant to perform validation of its universes for completeness and accuracy for select Part C core operational areas based on the final 2017 CMS Medicare Parts C and D Program Audit Protocols and the 2017 CMS Program Audit Protocols for Medicare-Medicaid Plans (MMPs). The data integrity testing was completed in September and

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remediation efforts are expected to continue through December 2018. CalOptima anticipates receiving the preliminary audit report by mid-December 2018.

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

  CalOptima is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis, and to share the results with its governing body. As such, CalOptima has engaged an independent consultant to conduct the audit to ensure that its Compliance Program is being administered effectively. The onsite audit took place the week of September 24 – 28, 2018, and covered all aspects of CalOptima's Compliance program, including but not limited to, delegation oversight, internal oversight, FWA, and general compliance activities. CalOptima anticipates receiving the preliminary audit report in October 2018.

2. Medi-Cal

- 2018 Medi-Cal Audit:

  The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 26, 2018 through March 9, 2018. The audit covered the period from February 1, 2017 through January 31, 2018. The audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. DHCS issued its draft audit report on August 27, 2018. The draft report contained only one (1) finding in the area of case management and care coordination. Specifically, DHCS cited that the "Plan did not ensure that Behavioral Health Treatment (BHT) services were provided and supervised under a Plan-approved behavioral treatment plan that included a transition plan, crisis plan, and parent/caregiver training." Once DHCS issues its final audit report and request for a Corrective Action Plan (CAP), CalOptima will have thirty (30) calendar days to submit its CAP response.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of September 2018.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal, OneCare, OneCare Connect, and PACE

- For the months of June through August 2018 (based on data from May through July 2018), monthly file reviews for internal CalOptima departments were suspended due to the annual validation audits in progress. In lieu of the monthly file reviews, CalOptima's Audit & Oversight department conducted an annual validation audit, including a desk review of applicable policies and procedures, to ensure that deficiencies identified throughout the year

have been remediated. Monthly file reviews for internal CalOptima departments resumed in September 2018 (based on August data).

2. 2017-2018 Annual Internal Validation Audit

- CalOptima's Audit & Oversight department will complete its annual internal validation audit of CalOptima departments in October 2018. The table below reflects the final audit scores for CalOptima departments. The deficiencies identified during the audit were primarily attributed to missing information in contracts and/or policies. The final audit scores for the Claims and Provider Relations departments are pending.

Department	Score
Case Management	100%
Customer Service - Enrollment and Reconciliation	100%
Grievance & Appeals Resolution Services	100%
Network Operations – Contracting	96.05%
PACE	100%
Pharmacy	100%
Quality Analytics – Access and Availability	98.95%
Quality Analytics – Credentialing	87.67%
Utilization Management	100%

3. Health Network Audits: Medi-Cal

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

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
May 2018	70%	78%	79%	85%	78%	91%	88%	88%	88%	88%	43%	57%	76%
June 2018	81%	78%	82%	77%	78%	86%	88%	80%	81%	86%	33%	72%	66%
July 2018	73%	83%	73%	72%	61%	83%	85%	82%	83%	79%	39%	70%	81%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Routine – 5 business days and Urgent – 72 hours)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
  - Failure to meet timeframe for extended decision (14 calendar days)
  - Failure to meet timeframe for member delay notification (5 business days)

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to cite criteria for decision
  - Failure to obtain adequate clinical information
  - Failure to have appropriate professional make decision

- The lower letter scores were due to the following reasons:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to provide member with information on how to file a grievance
  - Failure to provide letter in member's primary language
  - Failure to provide letter with description of services in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer
  - Failure to provide referral back to primary care provider (PCP) on denial letter
  - Failure to include name and contact information for health care professional responsible for the decision to deny

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2018	98%	99%	98%	85%
June 2018	93%	90%	98%	90%
July 2018	94%	89%	96%	98%

- The compliance rate for paid claims accuracy decreased from 90% in June 2018 to 89% in July 2018 due to missing documents required for processing accurate payment on claims.

- The compliance rate for denied claims timeliness decreased from 98% in June 2018 to 96% in July 2018 due to untimely processing of multiple claims.

4. Health Network Audits: OneCare

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
May 2018	80%	67%	81%	89%	84%	100%	75%	89%
June 2018	67%	100%	80%	100%	83%	100%	75%	90%
July 2018	73%	100%	89%	100%	86%	100%	75%	93%

  - No significant trends to report.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2018	98%	98%	100%	98%
June 2018	100%	100%	93%	93%
July 2018	99%	99%	100%	93%

  - The compliance rate for paid claims timeliness decreased from 100% in June 2018 to 99% in July 2018 due to untimely processing of multiple claims.

  - The compliance rate for paid claims accuracy decreased from 100% in June 2018 to 99% in July 2018 due to missing documents required for processing accurate payment on claims.

5. Health Network Audits: OneCare Connect

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
May 2018	83%	50%	70%	85%	71%	63%	81%	85%	80%	66%	74%
June 2018	84%	84%	79%	81%	81%	58%	79%	80%	50%	67%	77%
July 2018	73%	67%	84%	87%	78%	58%	72%	85%	65%	58%	76%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent - 72 hours)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider written notification (24 hours)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to cite criteria for decision
  - Failure to obtain adequate clinical information

- The lower letter scores were due to the following reasons:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter in member's primary language
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to provide letter with description of services in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer
  - Failure to include name and contact information for health care professional responsible for the decision to deny

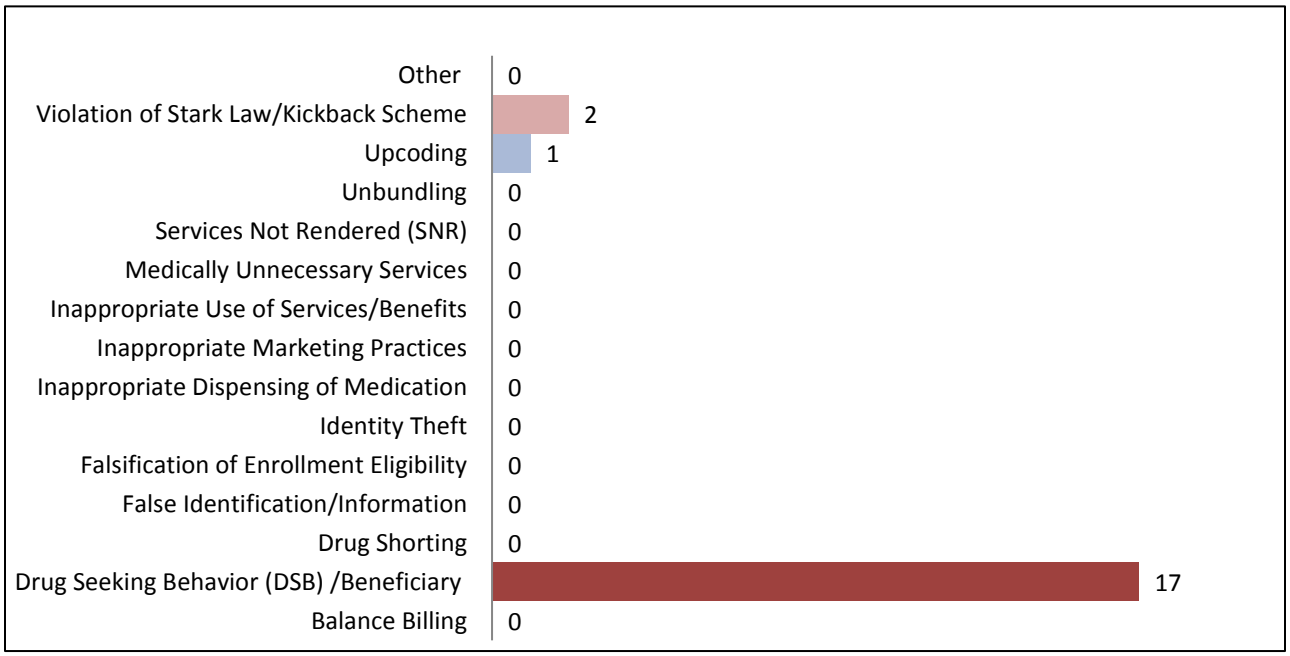
- OneCare Connect Claims: Professional Claims

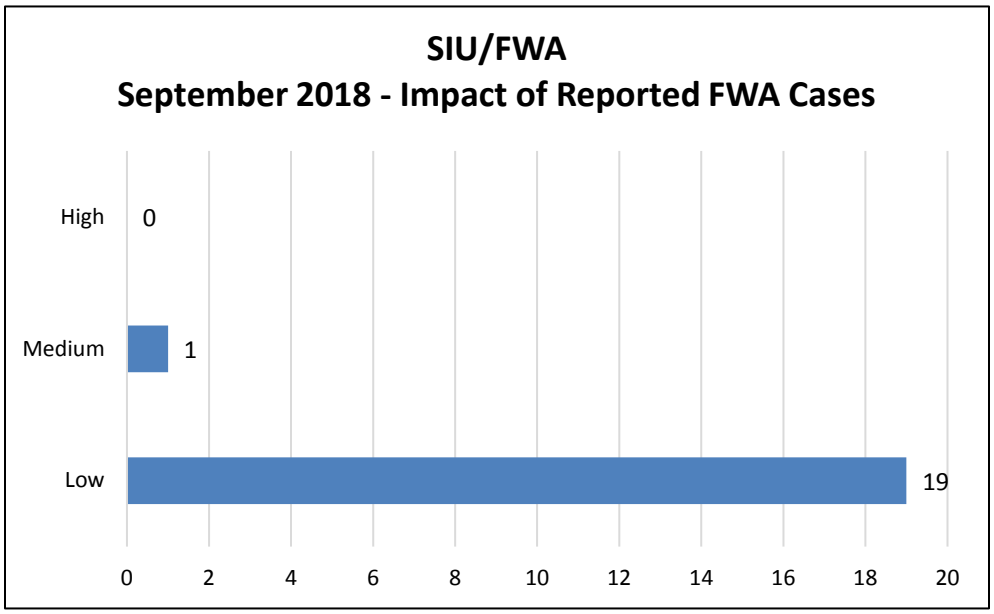
Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2018	96%	97%	100%	79%
June 2018	94%	97%	99%	91%
July 2018	92%	95%	98%	98%

- The compliance rate for paid claims timeliness decreased from 94% in June 2018 to 92% in July 2018 due to untimely processing of multiple claims.
- The compliance rate for paid claims accuracy decreased from 97% in June 2018 to 95% in July 2018 due to missing documents required for processing accurate payment on claims.
- The compliance rate for denied claims timeliness decreased from 99% in June 2018 to 98% in July 2018 due to untimely processing of multiple claims.

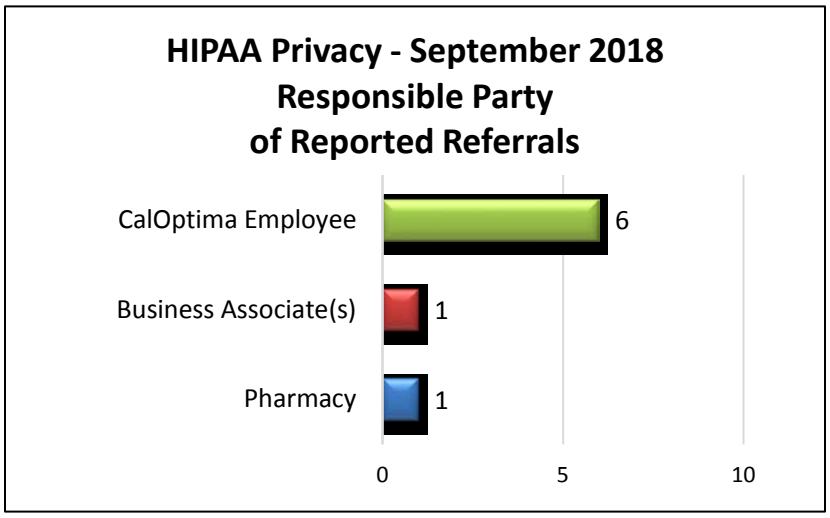
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

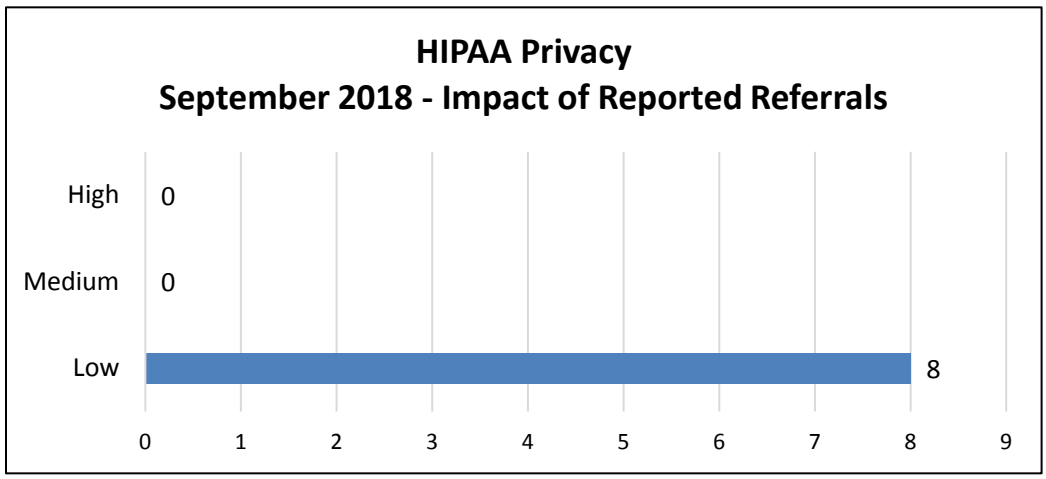
Types of FWA Cases: (Received in September 2018)





E. Privacy Update (September 2018)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	8
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**8**

A Public Agency

CalOptima

Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting

November 1, 2018

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

October 9, 2018

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: October Board of Directors Report

Congress was kept busy with several priorities last month as lawmakers raced to pass government spending bills prior to the end of the fiscal year and before going home to campaign ahead of the midterm elections in November. Members completed work on two of the most contentious appropriations bills, the Defense and Labor-HHS measures, and sent a long-awaited opioid response package to the President. While the House is now on recess, the Senate – which recently confirmed Brett Kavanaugh to the Supreme Court – will be in session for much of October.

Appropriations

Lawmakers avoided a government shutdown at the end of September after President Trump signed into law a Fiscal Year (FY) 2019 spending package that includes a Continuing Resolution (CR) to keep many federal agencies funded through December 7. H.R. 6157 also included full-year funding for the Department of Health and Human Services (HHS) and the Department of Defense. This is a major victory for Congress, marking the first time the Labor-HHS-Education appropriations bill has been enacted on time since 1996.

The $178 billion Labor-HHS bill includes a $2 billion funding increase for the National Institutes of Health (NIH) and provides $3.8 billion to combat the opioid crisis – an increase of $206 million over last year. This includes $1.5 billion for the State Opioid Response Grants, along with a 15-percent set aside for the states most affected by the opioid epidemic. Notably, the final package did not include a House provision calling for the disclosure of drug price information in direct-to-consumer advertising. Negotiators also stripped out controversial House provisions to defund Planned Parenthood.

This year's unusually bipartisan appropriations process also saw the President sign into law H.R. 5895, which provides full FY 2019 funding for the Department of Energy, the Department of Veterans Affairs (VA), and the Legislative Branch. All told, Congress approved three-fourths of annual discretionary funding on time. Congress will return to several funding fights after the midterm elections on November 6, however, with only four weeks to pass additional spending bills to avoid a December government shutdown.

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If the House flips to Democratic control, heightened partisan tensions could complicate already fractious negotiations over issues such as border wall funding and environmental policy. With Defense and VA spending already off the table, it may be difficult for Republican leaders to shore up conservatives' support for a government funding deal. Finally, it remains to be seen whether President Trump will be willing to shut down the government if Congress does not deliver additional funds for a U.S.-Mexico border wall. The President said last week that he will decide after the elections "as to whether or not we go for it."

Opioid Legislation

Following months of negotiations, House and Senate lawmakers on September 25 released the text of a compromise opioid package (H.R. 6). The House approved the conference agreement on September 28, and the Senate passed the bill on October 3. President Trump has indicated he will sign the measure into law.

The package authorizes new funding and resources for health care providers and includes policies to improve substance use disorder prevention, treatment and recovery. One major proposal would partially repeal the decades-old Institutions for Mental Disease (IMD) exclusion, which prohibits the use of federal Medicaid dollars for residential care at facilities with more than 16 beds. The limited repeal included in the bill would apply only to substance use disorder treatment and would expire after five years. The bill also includes provisions to crack down on the shipment of illicit drugs through the international mail and promote the development of non-opioid pain therapies.

Notably, the final bill does not include changes to 42 CFR Part 2 regulations regarding the confidentiality of substance use disorder patient records. Provisions to ease sharing of such records by aligning Part 2 rules with HIPAA were included in the House's legislative effort on opioids, but did not make it into the Senate's legislation. According to conversations with stakeholders involved in the negotiations, including these provisions in the bill was a challenge since the Democratic and Republican leaders of the Senate HELP Committee both had privacy concerns. Opposition from the American Medical Association, which sent a letter to House Energy & Commerce Committee leaders in middle of negotiations, also played a role in keeping the provisions out. The final bill does include provisions of Jessie's Law, which would require HHS to develop best practices to help providers access substance use disorder treatment information through electronic health records for consenting patients.

Brand name drug manufacturers were unable to secure inclusion of language to reduce their share of financial liability for beneficiaries in the Medicare Part D coverage gap, also known as

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the donut hole. A provision that increased manufacturers' share from 50 percent to 70 percent was included in the Bipartisan Budget Act of 2018.

ACE Kids Act

On September 13, the House Energy and Commerce Committee passed by voice vote H.R. 3325, the Advancing Care for Exceptional (ACE) Kids Act. The ACE Kids Act aims to improve the delivery of care for children with complex medical conditions who receive care under Medicaid. Building on the "health home" model that state Medicaid programs have used for certain populations, the bill would provide enhanced federal matching for a limited period of time for care coordination services for states that apply for the option. Akin Gump spoke with both Committee staff and staff for the lead sponsor, Rep. Joe Barton (R-TX-6), to ensure that the intent and effect of the bill's language is not to carve-out Medicaid plans from providing the services allowed under the bill. Passage of the legislation is a key priority for Rep. Barton, who is retiring at the end of this year.

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CalOptima Legislative Report
By Don Gilbert and Trent Smith
October 4, 2018

Governor Brown brought down the curtain on the 2018-2019 Legislative Session at midnight on September 30, the deadline to sign or veto approximately 1,500 bills that reached his desk. It was also the last major action he will take as Governor. Remaining consistent with the tight fiscal approach he exhibited over the previous seven years, the Governor vetoed many bills that had a cost to the state or the Medi-Cal program. Below is a short description, and the final outcome, of some bills we were involved with or monitoring on behalf of CalOptima, as well as, a few others that may be of interest.

AB 2499 (Arambula) – This measure clarifies the ACA requirement in California law that health plans must spend a minimum percent of premium on health care benefits (medical loss ratio), including 80 percent for individual coverage and 85 percent for a large group. The new law is consistent with federal standards in effect as of January 1, 2017, and ensures that a change in the ACA at the federal level will not eliminate this requirement in state law. AB 2499 was signed by the Governor.

SB 1108 (Hernandez) – This bill requires the Department of Health Care Services (DHCS) to seek future federal Medi-Cal waivers and pilots that aim to either increase the number of Medi-Cal recipients or enhance the medical assistance provided to recipients. As introduced, SB 1108 would have prevented DHCS from securing federal waivers that impose a work requirement for Medi-Cal recipients. However, this provision was removed from the bill late in the legislative process. Governor Brown signed SB 1108 into law.

AB 315 (Wood) – Assemblyman Wood's bill requires pharmacy benefit managers (PBMs) to register with the Department of Managed Health Care (DMHC) and to disclose specified information. The bill also requires DMHC to convene a task force on PBM reporting to determine what information on pharmaceutical costs should be reported to the state. This bill was signed by the Governor.

AB 2275 (Arambula) – AB 2275 would have required the Department of Health Care Services (DHCS) to establish a quality assessment and performance improvement program for Medi-Cal managed care plans. The Governor vetoed AB 2275, stating the bill would duplicate current efforts while adding significant costs to Medi-Cal.

AB 11 (McCarty and Bonta) – This measure would have required the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program to include developmental screening services for children zero to three. The Governor vetoed AB 11 arguing this service is not necessary because screening for developmental delays is

already required in the EPSDT program based on the schedule recommended by the American Academy of Pediatrics.

SB 1287 (Hernandez) – Another EPSDT bill, SB 1287 broadens the Medi-Cal definition of "medically necessary" for individuals under 21 years of age by incorporating the existing federal standards related to EPSDT services. The Governor signed SB 1287 into law.

AB 2299 (Chu) – Assemblyman Chu's bill would have required DHCS to ensure that written health education and informing materials, translated by managed care plans into Medi-Cal threshold languages (non-English languages spoken at a high proportional rate in a region), are at or below the equivalent of a sixth-grade reading level. It was not a surprise that the Governor vetoed this bill. In his veto message he wrote that current law and contracts with plans are sufficient to ensure plans make important health care documents understandable for Medi-Cal beneficiaries.

SB 1423 (Hernandez) – This simple bill modifies the minimum qualifications for an interpreter translating for limited-English-proficient Medi-Cal recipients enrolled in managed care.

SB 707 (Cannella) – SB 707 would have established the Medi-Cal Dental Advisory Group with the goal of increasing dental utilization rates and improving oral health within the Medi-Cal population. However, Governor Brown vetoed this bill, writing in his veto message that he has confidence that DHCS will engage with stakeholders in this matter, without the need for a public stakeholder process.

AB 180 (Wood) – Another bill vetoed by Governor Brown was AB 180. This bill would have required DHCS to establish a stakeholder process and develop guidance on what constitutes an incentive payment that can be excluded from the federally qualified health center (FQHC) or rural health clinic (RHC) Medi-Cal payment reconciliation process. The Governor's veto message expresses confidence that DHCS will engage with stakeholders in this matter, without the need for a public stakeholder process.

SB 1125 (Atkins) – An important bill for health clinics was SB 1125. If federal financial participation was available, SB 1125 would have permitted FQHCs and RHCs to be reimbursed for a maximum of two visits at a single location in a single day per patient, when the patient has a medical visit and either a mental health or dental visit on the same day. Unfortunately for the clinics, Governor Brown vetoed the measure on fiscal grounds, stating SB 1125 would require significant, ongoing general fund commitments; and therefore, the issue should be considered as part of the budget process.

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AB 2472 (Wood) – A bill we have written about previously, AB 2472 requires the newly-created Council on Health Care Delivery Systems to analyze the feasibility of a public option to increase competition and choice for health care consumers. Governor Brown signed AB 2472 into law.

SB 906 (Beall and Anderson) – One of several bills aimed at improving mental health services, SB 906 required DHCS to establish a program for certifying peer support specialists in mental illness. The bill also required DHCS to secure federal approval for peer support specialist services as a Medi-Cal benefit. Predictably, Governor Brown vetoed this bill, citing fiscal concerns. His veto message stated that SB 906 imposes a costly new program that would shut out some individuals already working as peer support specialists.

AB 2393 (Committee on Health) – A mental health bill that was signed by the Governor is AB 2393. This aligns federal requirements with state law by prohibiting a county mental health plan from charging fees for specialty mental health services for Medi-Cal recipients who do not have a share of cost or who have met their share of cost.

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2017–18 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 6157 Granger	**Health Human and Services (HHS) Appropriations/ Previous Spending Levels Continued:** Funds the Department of Health and Human Services (HHS) for fiscal year (FY) 2019, along with the Departments of Defense, Labor, and Education. This bill would provide $90.5 billion in discretionary funding for HHS programs and agencies in FY 2019 – a $2.3 billion increase over current funding levels. It is important to note that although Medicare and Medicaid are administered by HHS, they are not funded through the annual appropriations process. Like other entitlement programs, Medicare and Medicaid are supported by mandatory funding that flows automatically without requiring annual congressional approval. In addition to providing appropriations for HHS, Labor, Education and Defense programs, the bill includes language that would continue current spending levels through December 7 for any federal agencies and programs that have not received an appropriation by October 1, the beginning of the Federal Fiscal Year.	**09/28/2018** Signed into law **09/18/2018** Senate agreed to Conference Committee bill text **09/13/2018** Conference Committee agreed on text **08/23/2018** Passed Senate, with amendments **06/28/2018** Passed House of Representatives **06/20/2018** Introduced	Watch
H.R. 3325 Barton	**ACE Kids Act:** Would provide state Medicaid programs the option of providing medical assistance through a "health home" for children with medically complex conditions. State Medicaid agencies, like the Department of Health Care Services (DHCS), would have the option of submitting a state plan amendment to the Centers for Medicare & Medicaid Services (CMS) to participate in this program. Participating states would receive a higher Federal Medical Assistance Percentage (FMAP) for each child participating in this program. This bill would gives states the option to pay designated providers, such as children's hospitals, directly for the care of these children, which could result in these children being carved out of managed care.	**09/13/2018** Passed House Committee on Energy and Commerce **07/20/2018** Introduced	Watch CalOptima provided feedback to bill author
H.R. 6 Walden	**Opioids – Prescription Controls, Education/Prevention, and Provider Incentives:** The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act is a bipartisan effort in response to the national opioid crisis. The bill includes a broad range of provisions from multiple bills that were previously advanced through the House Energy and Commerce and Ways and Means Committees. There are several provisions relevant to the Medicaid and Medicare programs, including proposals to implement controls on pharmaceuticals to prevent inappropriate dispensation of opioids, expand access to effective addiction treatment, increase opioid misuse education and prevention efforts, and provide incentives to discourage physicians from over prescribing opioids.	**10/03/2018** Passed Senate and sent to the President **06/26/2018** Read in the Senate and placed on the Senate Legislative Calendar **06/22/2018** Passed the House **06/13/2018** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 6561 Walorski	**Programs of All-Inclusive Care for the Elderly (PACE) Final Rule:** Would direct the Secretary of Health and Human Services (HHS) to release the final PACE rule no later than December 31, 2018. The final rule would implement the first regulatory update to PACE regulations in more than ten years. The proposed changes include allowing PACE organizations (POs) to, (1) include community physicians as part of their hallmark interdisciplinary teams (IDTs); (2) use nurse practitioners and physician assistants as primary care providers; (3) provide services in settings other than the PACE Center, and; (4) configure the IDT to meet the needs of individual participants. Taken together these changes are likely to enable POs to accommodate more participants and expand their programs without compromising quality of care. CalOptima PACE has been an early adopter of many of these PACE innovations, applying for CMS exemptions to utilize community-based physicians, nurse practitioners, and the Alternative Care Setting (ACS) model to deliver PACE care outside of the PACE center.	**09/17/2018** Referred to Senate Committee on Finance **09/10/2018** Passed House, ordered to Senate **07/26/2018** Introduced and referred to the Committee on Ways and Means, and to the Committee on Energy and Commerce	Watch CalOptima provided feedback to members of OC congressional delegation
H.R. 6082 Mullin	**Confidentiality Regulations:** Would align the federal Confidentiality of Substance Use Disorder Patient Records regulations (42 USC 290dd-2 and 42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) as they relate to the disclosure of substance use disorder (SUD) treatment. This bill would authorize the disclosure of SUD patient records to a covered entity, such as CalOptima, for treatment, payment, and health care operations without a patient's written consent, which is required under current law. This change would simplify the process of coordinating behavioral and physical health services by allowing health plans and providers treating the same patient to access their member's SUD treatment information.	**06/21/2018** Referred to the Senate Committee on Health, Education, Labor, and Pensions **06/13/2018** Introduced	Watch CalOptima provided feedback to members of OC congressional delegation
H.R. 4957 Sanchez	**Improving Alzheimer's Care:** Among other provisions, would establish Alzheimer's models of care based on a comprehensive continuum of care, similar to care delivery in the Program of All-Inclusive Care for the Elderly (PACE).	**02/13/2018** Referred to House Committee on Ways and Means Subcommittee on Health **02/07/2018** Introduced in the House	Watch
H.R. 1625 Royce	**FY 2018 Federal Budget/Omnibus Spending Bill:** Funds the federal government for the remainder of the 2018 budget year, through September 30. The bill includes: • $1.3 trillion in overall spending • $403 billion in Medicaid spending (an increase of $25 billion or 7 percent, accounting for 1.8 million more Medicaid beneficiaries and an increase in opioid related funding, among other factors) • $3.6 billion for opioid-addiction and mental health services (an increase of $2.55 billion or 244 percent) Of note, the bill did not include any stabilization measures for the individual market, such as the cost-sharing reduction payments or a federal reinsurance program.	**03/22/2018** Signed into law	Watch

2017–18 Legislative Tracking Matrix *(continued)*

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 1892 Larson	**FY 2018 Federal Budget/Previous Spending Levels Continued:** • Establishes a two-year budget framework and continues current federal spending levels until March 23, 2018. • Permanently reauthorizes Dual Eligible Special Needs Plans (including CalOptima's OneCare program). • Extends reauthorization for the Children's Health Insurance Program (CHIP) until 2027. • Extends the Community Health Center Fund (CHCF) for two years.	**02/09/2018** Signed into law	CalOptima sent letter of support for CHIP, D-SNP and CHCF
H.R. 195 Russell	**FY 2018 Federal Budget/Previous Spending Levels Continued:** Extends current federal discretionary spending until February 8, 2018. Also authorizes CHIP funding for six years, until 2023, and gradually phases down the enhanced federal matching rate – 88/12 federal/state, to the regular CHIP rate – 65/35 federal/state in FY 2021.	**01/22/2018** Signed into law	CalOptima sent letter of support for CHIP
H.R. 1 Brady	**Tax Cuts and Jobs Act:** Amends portions of the Internal Revenue Code that address corporate and individual tax rates and deductions. It also eliminates the Affordable Care Act's (ACA) individual mandate, effective December 31, 2018.	**12/22/2017** Signed into law	Watch
H.R. 3922 Walden	**Five Year CHIP Re-authorization:** Would have extended federal CHIP funding, which expired on September 30, 2017, for five years. Would have retained the current ACA mandated state/federal CHIP matching rate (88/12 for California) for two years, reduced it by 11.5 percent for one year (76.5/23.5), and reverted to pre-ACA levels for two years (65/35). Also included spending offsets such as increasing Medicare premiums for beneficiaries who make more than $500,000 annually, requiring Medicaid beneficiaries to report lottery winnings as income, and decreasing funding for the ACA-enacted Prevention and Public Health Fund. Of note, H.R. 1892, referenced above, extends federal CHIP funding until 2027, and was signed into law on 02/09/2018.	**11/03/2017** Passed House, ordered to Senate **02/09/2018** 10-year reauthorization of CHIP funding included as part of H.R. 1892 (Larson)	CalOptima sent letter of support for CHIP
H. Concurrent Resolution 71 Black	**FY 2018 Budget Resolution:** The annual budget resolution sets the budgetary framework for the upcoming fiscal year and allows Congress to pass reconciliation legislation, which requires 51 votes to pass the Senate rather than the normal 60-vote threshold. While the budget resolution is non-binding and does not appropriate federal dollars, it does outline spending priorities for the remainder of the unfunded fiscal year (December 9, 2017 - September 30, 2018).	**10/26/2017** Passed House and Senate (Budget resolutions do not require a Presidential signature)	Watch
H.R. 601 Lowey	**FY 2018 Federal Budget/Previous Spending Levels Continued:** Extends current federal discretionary spending ($1.24 trillion overall) and raises the debt ceiling through December 8, 2017. Ensures funding for federal agencies such as the U.S. Department of Health and Human Services (HHS) continues at approximately $65 billion per year. Mandatory spending ($2.54 trillion overall) for programs such as Medicare and Medicaid continues at previous levels, less a small percentage, as required by the terms of the Budget Control Act of 2011.	**09/08/2017** Signed into law	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
Bipartisan Health Care Stabilization Act of 2017 Alexander/ Murray	**Marketplace Stabilization:** Would fund cost-sharing reductions (CSRs) – federal payments to marketplace insurers to reduce deductibles and co-pays for consumers earning between 139-250 percent of the federal poverty level (FPL) who have a "silver" level plan – through 2019. Also, would increase flexibility and streamline the state waiver approval process, among other changes. While this bill does not impact Medicaid directly, it is of interest to CalOptima because of its impact on the health care system, and, because it is common for Medicaid members to "churn" between Medicaid and the individual market.	**10/19/2017** Draft bill text released	Watch
S. 1804 Sanders	**Medicare for All:** Would replace the current U.S. health care system with a single-payer system, known as "Medicare for All." This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs, as well as most forms of private insurance, and enroll all eligible individuals into the new universal plan.	**09/13/2017** Referred to Senate Committee on Finance	Watch
H.R. 676 Ellison	**Medicare for All:** Similar to S. 1804, would replace the current U.S. health care system with a single-payer system, known as "Medicare for All." This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs as well as most forms of private insurance. The program would be funded via existing sources of government revenues for health care and by increasing personal income taxes on the top five percent of income earners, among other measures.	**01/24/2018** Referred to House Committee on Energy and Commerce, House Committee on Ways and Means, and the House Committee on Natural Resources	Watch

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 840 Mitchell	**Budget Act of 2018:** Funds the state government for the 2018-2019 fiscal year. The Medi-Cal allocation is $104.4 billion, including $23 billion general fund. The following allocations impact the Medi-Cal program: • Medi-Cal Expansion Population: $18.7 billion ($1.7 billion GF) • Coverage for children regardless of immigration status: $365.2 million ($287.7 million GF) • Breast and Cervical Cancer Treatment Coverage: $8.4 million GF • Supplemental Provider Payment: $710 million (from Proposition 56) *The Budget Act is the predominant method by which appropriations are made to fund the state government. A budget bill is introduced by January 10 and the Legislature is required to pass the budget bill by June 15. The Budget Bill becomes the Budget Act upon the Governor's signature.*	**06/27/2018** Signed into law by the Governor	Watch
SB 856 Senate Budget Committee	**Junior Budget Bill:** Makes changes and corrections to the Budget Act of 2018, such as appropriating Proposition 56 tobacco tax revenue and related federal funds for Medi-Cal, among other provisions. This bill allocates up to $500 million for supplemental payments for physician services and directs the Department of Health Care Services (DHCS) to develop the methodology for distributing these payments as well as post the proposed payment structure on its website by September 30, 2018. *The Junior Budget Bill is the method by which amendments are made to the chaptered Budget Act.*	**06/27/2018** Signed into law by the Governor	Watch
SB 849 Senate Budget Committee	**Medi-Cal Trailer Bill:** Budget trailer bill that makes appropriations related to Proposition 56 supplemental payments (in conjunction with SB 856) and creates a dental integration pilot program in San Mateo County (carving dental into managed care), among other provisions. *When budget changes proposed by the Governor require changes to existing law, the legislation introduces separate legislation, referred to as "trailer bills," which are heard concurrently with the Budget Bill.*	**06/27/2018** Signed into law by the Governor	Watch
SB 850 Senate Budget Committee	**Homeless Emergency Aid program and Orange County Shelter:** Establishes the Homeless Emergency Aid program to provide local governments with one-time flexible block grant funds to address their immediate homelessness challenges. The bill requires the Business, Consumer Services, and Housing Agency to allocate a total of $500 million among local governments, with funding allocated according to homeless point-in-time counts, proportionate share of total homeless population, as well as direct allocations to cities and counties with populations over 330,000. This bill also requires DHCS to allocate $5 million to the Bridges at Kraemer Place emergency shelter in Orange County to create a homeless navigation center.	**06/27/2018** Signed into law by the Governor	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
RN 1802014 Trailer Bill – 340B Drug Program	**340B Drug Purchasing Program:** Would prohibit the use of 340B discounted drugs in Medi-Cal starting July 1, 2019, pending approval from CMS. Section 340B of the Public Health Service Act allows certain hospitals and clinics to purchase pharmaceuticals at discounted prices. Federal and state agencies have found inconsistencies with the program's implementation. According to DHCS, these inconsistencies create a substantial administrative burden on the state. As such, the Department's proposed trailer bill language seeks to prohibit the use of 340B drugs in Medi-Cal. In the event that CMS does not grant the state permission to entirely exclude 340B drugs from Medi-Cal, the state will seek CMS approval for limiting the use of 340B drugs in Medi-Cal. Although this trailer bill language was not included in the final Budget deal, DHCS is likely to continue efforts to reform the 340B program through the regulatory process.	**05/15/2018** Heard in Senate Budget Subcommittee No. 3: Health and Human Services **01/16/2018** Trailer bill language published on the Department of Finance website	Watch CalOptima provided feedback as part of the CAHP and LHPC comment letters to DHCS
AB 2331 Weber	**Medi-Cal Eligibility Redetermination:** Would allow developmentally disabled individuals receiving services at regional centers to remain continuously eligible for Medi-Cal. Rather than the beneficiary being responsible for ensuring that annual redetermination is performed, counties will use information provided by the California Department of Developmental Services (DDS) and DHCS to ensure that they meet Medi-Cal eligibility criteria.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/13/2018** Introduced	CalOptima sent letter of support LHPC: Support
AB 1963 Waldron	**Opioids – Treatment:** Would increase provider reimbursement rates for Medication-Assisted Treatments (MAT). MAT requires that patients receive counseling, behavioral therapies, and recovery support services in combination with prescribed medication, such as buprenorphine/naloxone, methadone, buprenorphine, and naltrexone. These therapies have proven to be very effective in treating opioid addiction. There is a significant shortage of providers certified to administer MAT treatments. Depending on how the reimbursement structure is constructed, a rate increase could potentially help CalOptima expand access to MAT services in Orange County.	**05/25/2018** Held under submission in Assembly Appropriations Committee **01/30/2018** Introduced	Watch CalOptima provided feedback to the bill author
AB 2741 Burke	**Opioids – Supply Limit:** Would prohibit providers from prescribing more than a five-day opioid supply to a minor, except in the case of pain associated with cancer, palliative or hospice care, chronic pain, and emergency services and care; and require parental consent for opioid prescriptions.	**06/18/2018** Held in the Senate Business, Professions and Economic Development Committee at the request of the author **05/07/2018** Passed Assembly Floor and ordered to the Senate **02/16/2018** Introduced	Watch CalOptima provided feedback to the bill author

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 1998 Rodriguez	**Opioids – Prescription Controls:** Would institute more stringent prescription controls related to opioids, including limiting opioid prescriptions to amounts sufficient for not more than three days. *Bills which are determined to exceed a cost impact of $150,000 are placed on "suspense file" to be heard by the Appropriations Committees at the suspense file hearing towards the end of the legislative cycle. If the bill moves out of the suspense file, it proceeds to the floor for a vote while bills held on suspense die.*	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/01/2018** Introduced	Watch
AB 2430 Arambula	**Medi-Cal Eligibility for Seniors:** Would adjust the income threshold for seniors eligible for Medi-Cal under the Aged and Disabled Federal Poverty Level Program from 123 percent FPL to 138 percent FPL, bringing it in line with other Medi-Cal programs for adult beneficiaries. Currently, seniors with income levels above 123 percent FPL are only eligible for Medi-Cal if they pay an added out of pocket expense known as "share of cost." Under share of cost, beneficiaries must take full responsibility for health care expenses up to a predetermined amount (share of cost) for the month in which they receive services. Once they meet their share of cost, Medi-Cal pays for any additional covered services for that month. This bill aims to ensure that low-income seniors have access to Medi-Cal at the same income level as most other adult beneficiaries, without incurring extra financial burdens.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/29/2018** Passed Assembly Floor and ordered to the Senate **02/14/2018** Introduced	Watch CAHP: Support LHPC: Support
SB 945 Atkins	**Breast and Cervical Cancer Treatment Program (BCCTP):** Would remove the 18 to 24-month cap on coverage under the state Breast and Cervical Cancer Treatment Program (BCCTP), which would allow members to remain in the program and CalOptima to continue receiving adequate reimbursement for the duration of their treatment. Currently, DHCS administers BCCTP, which provides cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer that meet certain screening and income eligibility criteria. Currently, for individuals enrolled in the state BCCTP program, treatment coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. Provisions from SB 945 were included as trailer bill language in AB 1810 (Committee on Budget, Assembly) which was signed into law eliminating the treatment term limits. The Budget includes $8.4 million General Fund allocation for this purpose.	**06/26/2018** Held in the Assembly Health Committee at the request of the author **05/29/2018** Passed Senate Floor and ordered to the Assembly **01/29/2018** Introduced	Watch LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2275 Arambula	**Medi-Cal Quality Requirements:** Would create new quality requirements for Medi-Cal managed care plans, which would be a significant departure from the state's current quality assurance and performance improvement program. Amended language allows National Committee for Quality Assurance (NCQA) accredited plans, like CalOptima, to submit survey data collected annually as part of the NCQA accreditation. *After bills are passed by the Legislation and are presented to the Governor, he has until September 30, 2018 to sign or veto bills, or he can choose to take no action, in which case a bill would become chaptered without his signature immediately after the September 30 deadline. A chaptered bill becomes effective January 1, 2019 unless it contains an urgency clause or specifies its own effective date.*	**09/12/2018** Vetoed by the Governor **09/06/2018** Sent to the Governor's Desk **08/28/2018** Assembly concurred in Senate amendments **02/13/2018** Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author
AB 2299 Chu	**Materials for Medi-Cal Members:** Requires all Medi-Cal managed care plans' (MCPs) written health education and informational materials to meet a readability and suitability checklist established by DHCS. Informational materials would also be required to go through a "community review" process prior to submission to DHCS. Under current state policy, MCPs are already required to meet readability and suitability standards for all written materials. Currently, CalOptima's Health Education and Cultural Linguistic Services departments already review all informational materials released to members in all threshold languages. This bill would add an additional step – the community review – to the current process. This additional step could delay the release of member materials for an additional 45 days. According to analysis conducted by staff, while the intent of the bill appears to benefit members, these added requirements would create unnecessary delays in releasing information to members.	**09/19/2018** Vetoed by the Governor **09/05/2018** Sent to the Governor's Desk **08/27/2018** Assembly concurred in Senate amendments **02/13/2018** Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author
AB 2579 Burke	**WIC to Medi-Cal Express Lane:** Would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to Medi-Cal. WIC is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/15/2018** Introduced	Watch CAHP: Support LHPC: Support

2017–18 Legislative Tracking Matrix *(continued)*

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2193 Maienschein	**Maternal Mental Health Program:** Requires health plans to develop a maternal mental health program to address mental health conditions that occur during pregnancy or postpartum period. Upon analysis by staff, CalOptima's Comprehensive Perinatal Services Program (CPSP) appears to comply with the requirements of the bill as these overlap with existing standards and requirements in Medi-Cal managed care contracts.	**09/26/2018** Signed into law by the Governor **09/06/2018** Sent to the Governor's Desk **08/29/18** Assembly concurred in Senate amendments **02/12/2018** Introduced	Watch CalOptima provided feedback to LHPC
SB 1125 Atkins	**Access to Mental Health at FQHCs:** Would allow a Federally Qualified Health Center (FQHC) to be reimbursed by the state for a mental health visit that occurs on the same day as a medical face-to-face visit. Currently, a patient must seek mental health treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would give members access to both primary care and on-site mental health care on the same day, while ensuring that clinics are appropriately reimbursed for both services. Currently, approximately 138,000 CalOptima members receive care at FQHCs.	**9/27/2018** Vetoed by the Governor **09/12/2018** Sent to the Governor's Desk **08/31/2018** Senate concurred in Assembly amendments **02/13/2018** Introduced	CalOptima sent letter of support LHPC: Support
AB 2029 Garcia	**Billable Visits for Service Outside the FQHC's Four Walls:** Among other provisions, this bill would align state and federal regulations to allow FQHCs to bill for services provided to CalOptima members outside the FQHC's four walls. Current federal law allows FQHCs to provide services to patients at temporary shelters, a beneficiary's residence, a location of another provider, or any location approved by the U.S. Health Resources and Services Administration (HRSA). Allowing FQHCs to bill for services outside their four walls would expand access to care for CalOptima members who are homebound, require specialized transportation or reside in temporary shelters.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **02/05/2018** Introduced	Watch CalOptima provided feedback as part of LHPC comment letter to the bill author
AB 2965 Arambula	**Medi-Cal Eligibility:** Extends full scope Medi-Cal coverage to eligible individuals who are under 26 years of age, regardless of immigration status.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/16/2018** Introduced	Watch CAHP: Support LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 974 Lara	**Medi-Cal Eligibility:** Extends full scope Medi-Cal coverage to eligible individuals who are 65 years of age or older, regardless of immigration status.	**08/16/2018** Held in Assembly Appropriations Committee Suspense File **05/30/2018** Passed Senate Floor and ordered to the Assembly **02/01/2018** Introduced	Watch LHPC: Support
AB 2718 Friedman	**Transitional Medi-Cal Eligibility for CalWORKs Recipients:** Extends Medi-Cal eligibility from six months to twelve months for families transitioning off the California Work Opportunity and Responsibility to Kids program (CalWORKs). Current state policy allows for a six-month extension of coverage after a family exits the program, and an additional six months if their income remains at or below 185 percent FPL. This bill would allow families to retain access to Medi-Cal coverage for twelve months, regardless of income, by requiring the state to implement the federally allowable twelve-month period option.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/15/2018** Introduced	Watch
AB 2203 Gray	**Medi-Cal Provider Rates:** Beginning July 1, 2019, would require DHCS to increase Medi-Cal primary care provider rates to the rate paid for those services under the federal Medicare program.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/12/2018** Introduced	Watch
AB 2122 Reyes	**Pediatric Blood Lead Testing:** Would require DHCS to notify parents of children enrolled in Medi-Cal of lead testing requirements and inform them when their children have missed the test. Under current law, children are to be tested at 12 months of age and again at 24 months. This bill would require DHCS to report its progress in meeting the lead testing requirements on an annual basis. Medi-Cal managed care plans would be required to notify and educate health care providers that fail to blood test at least eighty percent of enrolled children. According to the bill language, a disproportionate number of children who test positive for lead-poisoning are enrolled in Medi-Cal.	**09/22/2018** Vetoed by the Governor **09/10/2018** Sent to the Governor's Desk **08/30/2018** Assembly concurred in Senate amendments **02/08/2018** Introduced	Watch CalOptima provided feedback to the bill author

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2472 Wood	**Medi-Cal Public Option Feasibility Study:** Requires the newly established Council on Health Care Delivery System to prepare a feasibility study to assess the possibility of establishing a public health insurance plan. The plan would permit individuals whose income is greater than 138 percent of the federal poverty level to purchase coverage. Among other requirements, the study would explore the feasibility of allowing Medi-Cal managed care plans to negotiate with Covered California regarding offering products on the California Health Benefit Exchange in counties where only two or fewer plans are available for purchase through the Exchange.	**09/22/2018** Signed into law by the Governor **09/05/2018** Sent to the Governor's Desk **08/27/18** Assembly concurred in Senate amendments **02/14/2018** Introduced	Watch
AB 3175 Rubio	**Child Life Specialist:** Would require that services provided by certified child life specialists be covered under the California Children's Services (CCS) program. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with specialized health care conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, among others. CCS-eligible children living in select counties, including Orange County, will transition from fee-for-service to Medi-Cal managed care as part of the Whole Child Model (WCM), established as part of SB 586 (Chapter 625, Statutes of 2016). In Orange County, the CCS WCM transition is scheduled to take place in January 2019. Certified child life specialists are allied health care professionals that support children and families coping with the stress and uncertainty of life altering healthcare crises.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/16/2018** Introduced	Watch
SB 906 Beall	**Medi-Cal Mental Health Services Peer Certification:** Would require DHCS to establish a statewide certification program for peer and family support specialists and to include as a service to be reimbursed under the Medi-Cal program. Among other responsibilities, a peer and family support specialist would provide individualized support services to members with mental health care needs and substance use disorders.	**09/29/2018** Vetoed by the Governor **09/12/2018** Sent to the Governor's Desk **08/31/2018** Senate concurred in Assembly amendments **05/30/2018** Passed Senate Floor and ordered to the Assembly **01/17/2018** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 399 Portantino	**Autism Spectrum Disorder Treatment:** Would make changes to current law related to the treatment of Autism Spectrum Disorder, such that managed care plans would be required to cover certain treatment protocols that are not currently covered, such as the Developmental Individual-difference Relationship (DIR) model and "Floortime." These therapies are intended to be spontaneous play sessions between a child with autism and an adult. Also, this bill would reduce the required educational levels of autism service paraprofessionals.	**09/29/2018** Vetoed by the Governor **09/05/2018** Sent to the Governor's Desk **08/28/2018** Senate concurred in Assembly amendments **01/29/2018** Passed Senate Floor and ordered to the Assembly **02/15/2017** Introduced	Watch CAHP: Oppose LHPC: Oppose
AB 2565 Chiu	**Covered California Premium Assistance:** Would require Covered California to offer enhanced premium assistance to individuals between 200 percent and 400 percent FPL who enroll in health care coverage through the Exchange. The enhanced premium assistance would be in addition to the current federal subsidies. According to the bill author, the cost to the state would be $300 million, and would increase financial assistance to approximately 550,000 people enrolled in Covered California. While this bill does not impact Medi-Cal directly, it is of interest to CalOptima because individuals often "churn" between Medi-Cal and the individual market.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/15/2018** Introduced	Watch
SB 171 Hernandez	**Medicaid Managed Care Final Rule ("Mega Reg"):** Implements certain provisions of the Mega Reg by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill changes the way public hospitals receive supplemental payments and creates a new, across-the-board Medical Loss Ratio (MLR) standard for Medi-Cal managed care plans. DHCS received federal approval for the new public hospitals directed payment structure, comprised of the Enhanced Payment Program (EPP) and the Quality Incentive Program (QIP), in April 2018.	**10/13/2017** Signed into law by the Governor	Watch
SB 608 Hernandez	**Hospital Quality Assurance Fee (QAF):** Would modify the QAF to bring it into compliance with CMS Medicaid Managed Care Final Rule requirements. The current language of the bill only reflects a portion of the California Hospital Association's proposal to reform the QAF. DHCS received federal approval for the new Private Hospital Directed Payment (PHDP) structure in March 2018. The new structure begins a 10-year phase out of the current QAF structure and phase in of the PHDP.	**09/01/2017** Held under submission	Watch

CAHP: California Association of Health Plans
LHPC: Local Health Plans of California

Last Updated: October 1, 2018

2018 Federal Legislative Dates

January 3	116th Congress convenes 1st session
March 26–April 9	Spring recess
July 27–September 3	Summer recess
November 6	General Election

2018 State Legislative Dates

January 3	Legislature reconvenes
February 16	Last day for legislation to be introduced
April 27	Last day for policy committees to hear and report bills to fiscal committees
May 11	Last day for policy committees to hear and report non-fiscal bills to the floor
May 25	Last day for fiscal committees to report fiscal bills to the floor
May 29–June1	Floor session only
June 1	Last day to pass bills out of their house of origin
June 5	Statewide Primary Election
June 15	Budget bill must be passed by midnight
June 28	Last day for a legislative measure to qualify for the Nov. 6 General Election ballot
July 6–August 5	Summer recess
August 7	Special Election for CA Senate District 32
August 17	Last day for fiscal committees to report bills to the floor
August 20 – 31	Floor session only
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 6	General Election
November 30	Adjournment *Sine Die* at midnight
December 3	Convening of the 2019-20 session

Sources: 2018 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

Board of Directors Meeting
November 1, 2018

CalOptima Community Outreach Summary — October 2018

Background

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

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

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

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

CalOptima Resource Fair

In collaboration with Quality Analytics and Customer Service departments, Community Relations will be hosting a Mobile Mammogram Event on Tuesday, November 13, 2018, from 9 a.m.–Noon. The event will take place at the Miraloma Park and Family Resource Center located in the heart of Anaheim at 2600 E. Miraloma Way, Anaheim 92806. The purpose of the event is to ensure our members have good breast health and increase CalOptima's HEDIS measurement for breast cancer screenings.

Event invitations will be mailed directly to approximately 500 CCN and COD members, between the ages of 50 and 74 who live in Anaheim and are due for a mammogram. CalOptima's Customer Service will coordinate transportation for members who do not have access to transportation to attend the event. The event is also open to women who qualify for Orange County Health Care Agency's Every Woman Counts program, a program that provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured populations.

Community Relations will partner with Susan G. Komen, Orange County Health care Agency, and Marshall B. Ketchum University College of Pharmacy to provide health education, resources and health screenings such as

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glucose, blood pressure and BMI on the day of the event. Additionally, CCN and COD members who complete the mammogram and health screenings will receive a $15 gift card from CalOptima's Quality Analytics department, and Susan G. Komen will provide $15 gift card to participants for Every Woman Counts who complete screenings at the event. As the community health plan, CalOptima believes in supporting our community health care needs through vital health screenings such as these.

For additional information or questions, please contact Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities

During October 2018, CalOptima participated in 51 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
10/01/18	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting
10/02/18	• Collaborative to Assist Motel Families Meeting
10/03/18	• Orange County Aging Services Collaborative General Meeting • Anaheim Human Services Network Meeting • Orange County Healthy Aging Initiative Meeting • Connection Café hosted by Help Me Grow, Orange County
10/04/18	• Homeless Provider Forum
10/05/18	• Covered Orange County General Meeting • Help Me Grow Advisory Meeting • Orange County Strategic Plan for Aging — Healthcare Committee Meeting
10/08/18	• Orange County Veterans and Military Families Collaborative Meeting • Fullerton Collaborative Meeting
10/09/18	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting • Buena Clinton Collaborative Neighborhood Coalition Meeting
10/10/18	• Anaheim Homeless Collaborative Meeting • Buena Park Collaborative Meeting • Health Care Task Force Meeting
10/11/18	• FOCUS Collaborative Meeting • 2018 Orange County Community Enroller Summit • Kid Healthy Community Advisory Committee Meeting
10/12/18	• Senior Citizens Advisory Council Board Meeting

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10/16/18	• Placentia Community Collaborative Meeting
10/17/18	• Covered Orange County Steering Committee Meeting • Minnie Street Family Resource Center Professional Roundtable • Orange County Promotoras Meeting • La Habra Move More, Eat Healthy Campaign Meeting
10/18/18	• Orange County Children's Partnership Committee • Orange County Women's Health Project Advisory Board Meeting • Surf City Senior Providers Network and Luncheon
10/22/18	• Community Health Research and Exchange Meeting
10/23/18	• Orange County Senior Roundtable • Santa Ana Building Healthy Communities
10/25/18	• Disability Coalition of Orange County Meeting • Orange County Care Coordination for Kids

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
10/01/18	1	• Annual International Older Adults Fair hosted by City of Santa Ana Senior Center
10/05/18	1	• Annual Senior Wellness Fair hosted by City of Orange Senior Center
10/06/18	2	• Annual Walk-A-Thon Community Resource Fair and Cultural Festival hosted by Madison Park Neighborhood Association (Sponsorship Fee: $1,000 included logo on T-shirts, posters and fliers, special recognition by City of Santa Ana during event, and an outreach table at the event.)
10/12/18	4	• Orange County Women's Health Summit hosted by Orange County Women's Health Project (Sponsorship Fee: $1,000 included logo recognition on website and on all marketing materials for summit, recognition on social media, on printed program and welcome signage for summit, 2 tickets and reserved seating at film screening, registration and reserved seating for 2 guests at summit, and an exhibit table for outreach at summit.)
	1	• Health Fair and Flu Clinic hosted by City of Brea Senior Center (Registration Fee: $60 included one resource table for outreach during the event.)
10/13/18	2	• Diocesan Ministries Celebration and Resource Fair hosted by Diocese of Orange (Registration Fee: $650 included full page ad in registration brochure and day of event program, and an exhibit table at the event.) • Domestic Violence Awareness Concert hosted by Casa De La Familia

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10/14/18	2	• OC Free Health Fair hosted by Vietnamese Physicians Association of Southern California (VPASC) Foundation (Sponsorship Fee: $3,000 included one outreach table, name on bottom of fliers, email blast, website, social media, radio/newspaper recognition, one banner displayed inside event area, and business cards/brochures in attendee gift bag.)
10/15/18	2	• Resource Fair hosted by Project Access, Inc.
10/20/18	1	• Senior Health and Resources Fair hosted by OASIS Senior Center (Sponsorship Fee: $1,000 included first choice of booth location, recognition on giveaways, event program, and any marketing material, day of event signage and during breakfast.)
	1	• Parkinson Interactive Conference for Latino Community hosted by Give for a Smile (Registration Fee: $1,500 included logo on all printed materials, welcome packages, press releases and event host webpage, recognition in presentations during general sessions, seating for sponsor representative at luncheon's head table and exhibition space.) • Harvesting Opportunities hosted by North Orange Continuing Education
10/24/18	1	• Medicare Info Fair hosted by City of Cypress (Registration Fee: $50 included one resource table for outreach)
10/25/18	3	• Annual Dia de los Muertos (Day of the Dead) hosted by City of Garden Grove Buena Clinton Youth and Family Center (Sponsorship Fee: $1,000 included peaking opportunity, photo op with award recipient, recognition of sponsorship with a plaque, agency logo on all marketing media for event including print, website and emailing list, and an outreach table with signage.)
10/27/18	2	• Health Fair hosted by Cal State Fullerton Center for Healthy Neighborhood
10/28/18	2	• Annual Conference hosted by the National Association for the Education of Homeless Children and Youth (Registration Fee: $250 included a table for outreach at the event.)
10/30/18	1	• Annual Picnic and Health Fair hosted by Living Opportunities Management Company

CalOptima organized or convened the following 19 community stakeholder events, meetings and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
10/02/18	• County Community Service Center Health Seminar — Topic: Fire Safety and Prevention (Vietnamese)

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10/03/18	• CalOptima Community Presentation for Boat People SOS-CA — Topic: Transportation Benefits
10/04/18	• CalOptima Health Education Workshop — Topic: Shape Your Life
10/09/18	• CalOptima New Member Orientation (English and Spanish)
10/10/18	• CalOptima New Member Orientation (Farsi and Korean) • Whole-Child Model Family Night Event at Regional Center of Orange County, West Area Office
10/11/18	• CalOptima Health Education Workshop — Topic: Shape Your Life • Whole-Child Model Family Night Event at Regional Center of Orange County, Central Area Office • CalOptima Community Presentation for Orange County Health Care Agency — Topic: Transportation Benefits
10/16/18	• Whole-Child Model Family Night Event at CalOptima
10/17/18	• Whole-Child Model Family Night Event at Boys & Girls Club, Irvine
10/18/18	• CalOptima Health Education Workshop — Topic: Shape Your Life • CalOptima Health Network Forum
10/19/18	• CalOptima Legislative Luncheon
10/20/18	• Health and Wellness Event at CalOptima PACE
10/24/18	• Whole-Child Model Family Night Event at Downtown Anaheim Community Center
10/25/18	• CalOptima Community Resource Fair • CalOptima New Member Orientation (Chinese, Arabic and Vietnamese)
10/31/18	• CalOptima Cafecito Meeting — Topic: Long-Term Care Support Services

CalOptima provided zero endorsements for events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo).

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CalOptima Board of Directors
Community Activities

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

November

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Thursday, 11/1 9-10:30am	++Refugee Forum of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Access California Services 631 S. Brookhurst St. Anaheim
Thursday, 11/1 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Friday, 11/2 9am-12pm	+City of Tustin Resource Fair and Flu Shot Clinic	Health/Resource Fair Open to the Public	Registration Fee $25 1 Staff	Tustin Area Senior Center 200 South C St. Tustin
Saturday, 11/3 7:30am-2pm	+Alzheimer's Orange County Annual Alzheimer's Latino Conference hosted	Health/Resource Fair Open to the Public	Sponsorship $2,500 2 Staff	Templo Calvario Church 2501 W. 5th St Santa Ana
Monday, 11/5 1-4pm	++OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 11/6 9:30-11am	++Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Downtown Anaheim Community Center 250 E. Center St. Anaheim

* *CalOptima Hosted*

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

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Tuesday-Thursday 11/6-11/8 8am-5pm	+California Association for Adult Day Services Annual Meeting	Conference Health/Resource Fair Open to the Public	Registration Fee $950 2 Staff	Sheraton Park Hotel 1855 S. Harbor Blvd. Anaheim
Wednesday, 11/7 3:30-5pm	*CalOptima Informational Series	Community Presentation Open to the Public	N/A	CalOptima
Thursday, 11/8 11:30am-12:30pm	++FOCUS Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove
Thursday, 11/8 3:30-5:30pm	++State Council on Developmental Disabilities Regional Advisory Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	State Council on Developmental Disabilities 2000 East Fourth St. Santa Ana
Saturday, 11/10 10am-4pm	+Office of Assemblyman Brough and Senator Bates the Office of Assemblyman Brough Veterans Resource Fair	Health/Resource Fair Open to the Public	1 Staff	Saddleback College Baseball Field 28000 Marguerite Pkwy Mission Viejo
Monday, 11/12 1-2:30pm	++OC Veterans and Military Families Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 11/12 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 11/13 9-10:30am	++Orange County Strategic Plan for Aging-Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 11/13 1-2pm	*CalOptima New Member Orientation *Presentation in English and Spanish*	Community Presentation Open to the public	1 Staff	CalOptima
Tuesday, 11/13 2-4pm	++Susan G. Komen Orange County - Unidos Contra el Cancer del Seno Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen Orange County 2817 McGaw Ave. Irvine

+ Exhibitor/Attendee
++ Meeting Attendee

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Wednesday 11/14 10-11am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday 11/14 10-11am	*CalOptima New Member Orientation *Presentation in Korean and Farsi*	Community Presentation Open to the public	1 Staff	CalOptima
Wednesday, 11/14 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Thursday, 11/15 8:30-10am	++OC Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Friday, 11/15 2:30-4:30pm	+OC Women's Health Project Advisory Meeting	Conference Open to the Public. Registration recommended.	N/A	The Village 1505 E. 17th St. Santa Ana
Tuesday, 11/20 8:30-10am	+North Orange County Senior Collaborative All Members Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 11/20 8:30-10am	+Orange County Cancer Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	American Cancer Society 1940 E. Deere Ave. Santa Ana
Tuesday, 11/20 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave. Placentia
Wednesday, 11/21 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana

Wednesday, 11/21 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Wednesday, 11/21 1:30-3pm	++La Habra Move More, Eat Health Campaign	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Thursday, 11/22 8:30-10am	++Disability Coalition of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 11/22 1-3pm	++Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Red Hill Ave. Santa Ana
Tuesday, 11/27 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Tuesday, 11/27 7:30-9am	++Santa Ana Building Healthy Communities	Steering Committee Meeting: Open to Collaborative Members	N/A	KidWorks 1902 W. Chestnut Ave. Santa Ana
Thursday, 11/29 10-11am	*CalOptima New Member Orientation *Presentation in Chinese and Arabic*	Community Presentation Open to the public	1 Staff	CalOptima